

Ohio Conference of Plasterers and Cement Masons
Health and Welfare Fund

3660 Stutz Drive, Suite 101 • Canfield, Ohio 44406
Telephone: (330) 779-8860 • Toll Free 1-800-435-2388

MEMORANDUM

TO: Medicare Retirees and Medicare Dependents
FROM: The Board of Trustees
RE: Monthly Premium Rate for 2027
DATE: October 2026

The Board of Trustees are pleased to announce that the 2027 monthly premium for your Dental, Vision, and Hearing benefits will remain unchanged and that benefits will continue to be offered through Humana. The rates of coverage will remain as follows:

Category	Current Rates
Single	\$232
Family (both over 65)	\$464
Family (one 62-65, one over 65)	\$828
Family (one under 62)	\$849

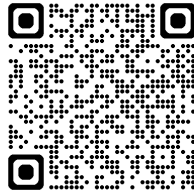
Included in this mailing is the 2027 Summary of Benefits for the medical (PPO) and prescription (PDP) Plans. Please be advised that the Dental Benefits for 2027 have been enhanced and are reflected on page 9 of the PPO Summary of Benefits. Also be advised that Humana will be sending a new identification card to use for services in 2027.

If you should have any questions regarding your Medicare Retiree coverage please use the contact information below:

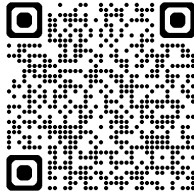
Contact...	To...	How...
Humana	Learn about Plan Benefits Ask about prescription drugs Find a provider	www.humana.com/medicare 1-800-457-4708 (TTY 711), 8:00 a.m. – 8:00 p.m., 7 days a week
Fund Office	Ask about eligibility	(330) 779-8860

You can also look a provider up using the QR codes on the next page.

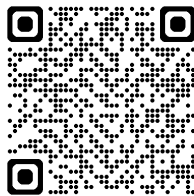
Find a Dental Provider:



Find a Vision Provider:



Find a TruHearing Provider:



2027

Summary of Benefits

**Humana Group Medicare Advantage PPO Plan
PPO 079/856**

Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund



Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major U.S. territories.



Let's talk about the **Humana Group Medicare Advantage PPO Plan.**

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage."

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Humana Group Medicare Customer Care.

Plan name:

Humana Group Medicare Advantage PPO plan



A healthy partnership

Get more from this plan — with extra services and resources provided by Humana!

How to reach us:

Members should call toll-free
1-800-733-9064 for questions
(TTY/TDD: 711)

Call Monday – Friday, 8 a.m. – 9 p.m.,
Eastern time.

Or visit our website: **Humana.com**



Monthly Premium, Deductible and Limits

PLAN COSTS

Monthly premium

You must keep paying your Medicare Part B premium.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

Medical deductible

This plan does not have a deductible.

Medical Maximum out-of-pocket responsibility

The most you pay for copays, coinsurance and other costs for medical services for the year.

In-Network Maximum Out-of-Pocket

\$0 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; Vision Services (Routine) and the Plan Premium do not apply to the in-network maximum out-of-pocket.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Combined In and Out-of-Network Maximum Out-of-Pocket

\$0 out-of-pocket limit for Medicare-covered services.

In-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy, Dental Services (Routine); Fitness Program; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.

Your limit for services received from in-network providers will count toward this limit.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	\$0 per admit	\$0 per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Diagnostic mammography	\$0 copay	\$0 copay
Observation services	\$0 copay	\$0 copay
Surgery services	\$0 copay	\$0 copay
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	\$0 copay	\$0 copay
Surgery services	\$0 copay	\$0 copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	\$0 copay	\$0 copay
Specialists	\$0 copay	\$0 copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
This plan covers all Medicare preventative services including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes self-management training • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Kidney disease education services • Lung cancer screening • Medical nutrition therapy • Obesity screening and therapy • Physical exams (routine) • Prostate cancer screening exam • Smoking and tobacco use cessation • STI screening and counseling • "Welcome to Medicare" preventative visit	Covered at no cost	Covered at no cost
• Immunizations • Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	Covered at no cost	Covered at no cost

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency room	\$0 copay for Medicare-covered emergency room visit(s)	\$0 copay for Medicare-covered emergency room visit(s)
Urgently needed services		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Urgent care center	\$0 copay	\$0 copay
Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.		
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT Scan)		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Freestanding radiological facility	\$0 copay	\$0 copay
• Outpatient Hospital	\$0 copay	\$0 copay
Diagnostic mammography		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Freestanding radiological facility	\$0 copay	\$0 copay
• Outpatient Hospital	\$0 copay	\$0 copay
Diagnostic procedures and tests		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Urgent care center	\$0 copay	\$0 copay
• Freestanding radiological facility	\$0 copay	\$0 copay
• Outpatient Hospital	\$0 copay	\$0 copay
EKG screening		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Freestanding radiological facility	\$0 copay	\$0 copay
• Outpatient Hospital	\$0 copay	\$0 copay
Lab services		
• Primary care provider (PCP)	\$0 copay	\$0 copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Specialist's office • Urgent care center • Freestanding laboratory • Outpatient Hospital	\$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay \$0 copay
Nuclear medicine services		
• Freestanding radiological facility • Outpatient Hospital	\$0 copay \$0 copay	\$0 copay \$0 copay
Outpatient x-rays		
• Primary care provider (PCP) • Specialist's office • Urgent care center • Freestanding radiological facility • Outpatient Hospital	\$0 copay \$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay \$0 copay \$0 copay
Radiation therapy		
• Specialist's office • Freestanding radiological facility • Outpatient Hospital	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay



HEARING SERVICES

Medicare-covered hearing: diagnostic hearing and balance exams	\$0 copay	\$0 copay
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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	\$0 copay for routine hearing exams up to 1 per year (includes hearing aid fitting). \$0 copay for follow-up provider visits up to 3 per year. \$1,500 maximum benefit coverage amount for hearing aid(s) (all types) up to 2 per year. Note: Includes 3 years of batteries per non-rechargeable aid (up to 60 cells per ear, per year) and 3 year warranty. Three follow-up provider visits during first year following hearing aid purchase, with the original provider.	95% of the cost for routine hearing exams up to 1 per year. 95% of the cost for follow-up provider visits up to 3 per year. 95% of the cost for each prescription hearing aid up to 2 per year. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.



DENTAL SERVICES

Medicare-covered dental	\$0 copay	\$0 copay
Routine dental	Preventive: 0% of the cost for periodic oral exam up to 2 per year. 0% of the cost for emergency diagnostic exam up to 1 per year. 0% of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% of the cost for prophylaxis (cleaning) and fluoride up to 2 per year each. 0% of the cost for full mouth or panoramic film or diagnostic x-rays up to 1 every 5 years. 0% of the cost for bitewing x-rays up to 1 set(s) per year. 0% of the cost for intraoral x-rays up to 1 per year. 0% of the cost for periodontal maintenance up to 4 per year.	Preventive: 0% of the cost for periodic oral exam up to 2 per year. 0% of the cost for emergency diagnostic exam up to 1 per year. 0% of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% of the cost for prophylaxis (cleaning) and fluoride up to 2 per year each. 0% of the cost for full mouth or panoramic film or diagnostic x-rays up to 1 every 5 years. 0% of the cost for bitewing x-rays up to 1 set(s) per year. 0% of the cost for intraoral x-rays up to 1 per year. 0% of the cost for periodontal maintenance up to 4 per year.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

IN-NETWORK	OUT-OF-NETWORK
0% of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/a nalgesia) with covered service up to as needed with covered codes per year. Preventive benefits are 100% covered and do not apply to the combined maximum benefit coverage. Comprehensive: 0% of the cost for amalgam and/or composite filling, emergency treatment for pain up to 2 per year each. 0% of the cost for simple or surgical extraction up to unlimited per year. 0% of the cost for root canal or retreatment up to 1 per year. 0% of the cost for periodontal scaling and root planing up to 1 per quadrant every 3 years. 0% of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. 0% of the cost for complete dentures, partial dentures up to 1 set every 5 years each. 0% of the cost for adjustments to dentures, denture reline, denture rebase, denture repair, tissue conditioning up to 1 per year each. 0% of the cost for crown, oral surgery up to 2 per year each. 0% of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. \$2,000 combined maximum benefit coverage amount per year for comprehensive benefits.	0% of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/a nalgesia) with covered service up to as needed with covered codes per year. Preventive benefits are 100% covered and do not apply to the combined maximum benefit coverage. Comprehensive: 0% of the cost for amalgam and/or composite filling, emergency treatment for pain up to 2 per year each. 0% of the cost for simple or surgical extraction up to unlimited per year. 0% of the cost for root canal or retreatment up to 1 per year. 0% of the cost for periodontal scaling and root planing up to 1 per quadrant every 3 years. 0% of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. 0% of the cost for complete dentures, partial dentures up to 1 set every 5 years each. 0% of the cost for adjustments to dentures, denture reline, denture rebase, denture repair, tissue conditioning up to 1 per year each. 0% of the cost for crown, oral surgery up to 2 per year each. 0% of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. \$2,000 combined maximum benefit coverage amount per year for comprehensive benefits. Benefits received out-of-network are subject to any in-network

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Covered Medical Benefits

IN-NETWORK

OUT-OF-NETWORK

benefit maximums, limitations, and/or exclusions.

Limitations and exclusions may apply. Please see your Evidence of Coverage (EOC) for additional details. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at [Humana.com/sb](https://www.humana.com/sb).

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but any applicable coinsurance payment still applies). Visiting an in-network provider may result in significant savings.

Out-of-network dentists have not agreed to provide services at contracted fees. The out-of-network provider may bill the member for more than what the plan pays, even for services listed with no member cost share. Members are responsible for this difference between Humana's reimbursement and the out-of-network provider's charges. This is known as balance billing. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS)/usual-customary and reasonable fees in your area. See Chapter 2 Payment Requests Contact Information or visit [Humana.com](https://www.humana.com) for information on requesting reimbursement.

The Mandatory Supplemental Dental benefits are provided through the HumanaDental. Contact Customer Service to locate a provider.



VISION SERVICES

Medicare-covered vision services	\$0 copay	\$0 copay
Medicare-covered diabetic eye exam (1 per year)	\$0 copay	\$0 copay
Medicare-covered glaucoma screening (1 per year)	\$0 copay	\$0 copay
Medicare-covered eyewear (post-cataract)	\$0 copay	\$0 copay

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	\$0 copay for routine exam (includes refraction) up to 1 per year. \$250 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	\$0 copay for routine exam (includes refraction) up to 1 per year. \$175 combined maximum benefit coverage amount per year for routine exam (includes refraction). \$250 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	\$0 per admit	\$0 per admit
Partial Hospitalization	\$0 copay	\$0 copay
Intensive Outpatient Services	\$0 copay	\$0 copay
Outpatient group and individual therapy visits - Primary care provider (PCP) - Specialist's office - Urgent care - Outpatient Hospital	\$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay \$0 copay

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF.	\$0 copay per day for days 1-100	\$0 copay per day for days 1-100
No 3-day hospital stay is required. Plan pays \$0 after 100 days.		
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	\$0 copay	\$0 copay
TRANSPORTATION		
Uniformity Flexibility Non-Emergency Medical Transportation	\$0 copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	95% coinsurance for plan approved location by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	\$0 copay	\$0 copay
• Outpatient Hospital	\$0 copay	\$0 copay
Medicare Part B covered drugs		
• Primary care provider (PCP)	\$0 copay	\$0 copay

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
- Specialist's office - Outpatient Hospital - Pharmacy	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay
Medicare Part B insulin drugs		
- Primary care provider (PCP) - Specialist's office - Outpatient Hospital - Pharmacy	\$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay \$0 copay
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain	\$0 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	\$0 copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum		
- Primary care provider (PCP) - Specialist's office	\$0 copay \$0 copay	\$0 copay \$0 copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	\$0 copay	\$0 copay
DIABETES SERVICES AND SUPPLIES		
Continuous glucose monitor (CGM)		
- Durable medical equipment provider - Pharmacy - Preferred Pharmacy	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay Not Covered
Diabetes management training		
- Primary care provider (PCP) - Specialist's office - Outpatient hospital	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay \$0 copay
Diabetes monitoring supplies		
- Durable medical equipment provider - Pharmacy - Preferred diabetic supplier	\$0 copay \$0 copay \$0 copay	\$0 copay \$0 copay Not Covered

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diabetes screening		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	\$0 copay	\$0 copay
HOME HEALTH CARE		
	\$0 copay	\$0 copay
HOSPICE		
You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	\$0 copay	\$0 copay
• Pharmacy	\$0 copay	\$0 copay
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)		
• Medical supply provider	\$0 copay	\$0 copay
• Pharmacy	\$0 copay	\$0 copay
Prosthetics (artificial limbs or braces)		
• Prosthetics provider	\$0 copay	\$0 copay
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Urgent care	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	\$0 copay	\$0 copay
• Comprehensive outpatient rehab facility	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay

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Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Cardiac rehabilitation		
• Specialist's office	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
Occupational therapy		
• Specialist's office	\$0 copay	\$0 copay
• Comprehensive outpatient rehab facility	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
Physical therapy		
• Specialist's office	\$0 copay	\$0 copay
• Comprehensive outpatient rehab facility	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
Pulmonary rehabilitation		
• Specialist's office	\$0 copay	\$0 copay
• Comprehensive outpatient rehab facility	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
Speech therapy		
• Specialist's office	\$0 copay	\$0 copay
• Comprehensive outpatient rehab facility	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
Kidney disease education services		
• Primary care provider (PCP)	\$0 copay	\$0 copay
• Specialist's office	\$0 copay	\$0 copay
• Outpatient hospital	\$0 copay	\$0 copay
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	\$0 copay	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered

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Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.	\$0 copay	95% coinsurance for out-of-network fitness centers. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
HEALTH EDUCATION SERVICES		
Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	\$0 copay	Not Applicable

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Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
POST-DISCHARGE SERVICES		
- Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals. 2 meals per day for 14 days, up to 28 meals delivered to your door. - Transportation up to 12 one-way trips to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle. - In-network services must be scheduled by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.	\$0 copay per discharge event following each inpatient or skilled nursing facility stay.	95% coinsurance for out-of-network post-discharge services. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
SMOKING CESSATION (ADDITIONAL)		
A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	\$0 copay	Not Applicable

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Additional Benefits

IN-NETWORK

OUT-OF-NETWORK

UNIFORMITY FLEXIBILITY VIRTUAL CARDIAC RECOVERY

Delivered via telehealth, virtual cardiac recovery program provides up to 36 covered sessions to support recovery and reduce the risk of hospital readmission.

\$0 copay

95% coinsurance for cardiac recovery services provided via telehealth under virtual supervision by a physician or qualified practitioner. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]: ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፅ ያላቸው አገልግሎቶችም ይገኛሉ። በ

877-320-1235 (TTY: 711) ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتسقيط البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bàsòò [Bassa]: Wuḍu-xwíniín-mú-zà-zà kùà, hwòdǒ-fónó-nyò,, kè nyo-bǒ-po-kà bě bě wa nyuesé wíqí péré-pérédò kò. Ðá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòm sèvis ki disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d'assistance linguistique, d'aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

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ગુજરાતી [Gujarati]: મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

GHHNOA2026HUM_0526

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。 **877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាន់មុខផ្សេងៗសម្រាប់អ្នកប្រើប្រាស់។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໆສ່ວຍຄົນໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajilíí'ígíí bee ak'e'elyaaígíí t'áá jik'eh hólǫ́. **877-320-1235 (TTY: 711)** bich'í' hodíílnih.

नेपाली [Nepali]: निःशुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਾਮਾਨ, ਅਤੇ ਵਿਕਲਪਿਕ ਢਾਂਚੇ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

877-320-1235 (TTY: 711) اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn isẹ̀ àtìlẹ́hìn ìrànlowọ̀ èdè, àtì ọ̀nà kíkà míràn wà lárọ̀wótó lófẹ̀ẹ́. Pe **877-320-1235 (TTY: 711)**.



Find out **more**



You can see this plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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Humana[®]

Humana.com

SB079856EN27

Summary of Benefits

**Humana Group Medicare PDP
PDP 037/538**

Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund



Humana®

Our service area includes the United States and Puerto Rico.



Let's talk about the **Humana Group Medicare PDP.**

Find out more about the Humana Group Medicare PDP – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage."

To be eligible

To join the Humana Group Medicare PDP, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare PDP

How to reach us:

Members should call toll-free
1-800-733-9064 for questions
(TTY/TDD: 711)

Call Monday – Friday, 8 a.m. – 9 p.m.,
Eastern time.

Or visit our website: **Humana.com**



Deductible

Pharmacy (Part D) deductible

This plan does not have a deductible.



Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)

You pay the following until your total out-of-pocket drug costs reach **\$2,400**. Once you reach this amount, you will enter the Catastrophic Stage.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	20% of the cost	20% of the cost
2 (Preferred Brand)	20% of the cost	20% of the cost
3 (Non-Preferred Drug)	20% of the cost	20% of the cost
4 (Specialty Tier)	20% of the cost	20% of the cost
100-day supply		
1 (Generic or Preferred Generic)	20% of the cost	20% of the cost
2 (Preferred Brand)	20% of the cost	20% of the cost
3 (Non-Preferred Drug)	20% of the cost	20% of the cost
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit www.humana.com/SearchResources, locate Prescription Drug section, select www.humana.com/MedicareDrugList link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP2.

Important Message About What You Pay for Vaccines – This plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Humana Group Medicare Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **\$35** for a one-month supply of each insulin product covered by this plan, no matter what cost-sharing tier it's on. Note: Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

Catastrophic Coverage

After your total out-of-pocket costs reach **\$2,400**, you pay **\$0** for plan-covered Part D and plan-covered excluded drugs.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]: ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፅ ያላቸው አገልግሎቶችም ይገኛሉ። በ

877-320-1235 (TTY: 711) ላይ ይደውሉ።

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Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bàsà [Bassa]: Wuḍu-xwíniín-mú-zà-zà kùà, hwòdǒ-fónó-nyò,, kè nyo-bǒ-po-kà bě bě wa nyuésé wíqí péré-pérédò kò. Ðá **877-320-1235 (TTY: 711)**.

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Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòm sèvis ki disponib. Rele **877-320-1235 (TTY: 711)**.

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עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

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Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。 **877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាន់មុខផ្សេងៗសម្រាប់អ្នកប្រើប្រាស់។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

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Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajilíí'ígíí bee ak'e'elyaaígíí t'áá jik'eh hólǫ́. **877-320-1235 (TTY: 711)** bich'í' hodíílnih.

नेपाली [Nepali]: निःशुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਮਾਗਰੀ, ਅਤੇ ਵਿਕਲਪਿਕ ਢਾਂਚਾਕਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

877-320-1235 (TTY: 711) اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn isẹ̀ àtìlẹ́hìn ìrànlowọ̀ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wọ̀tó lófẹ̀ẹ̀. Pe **877-320-1235 (TTY: 711)**.



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