

2026

Summary of Benefits

**Humana Group Medicare Advantage HMO Plan
HMO 076/609**

State of Florida

Department of
**MANAGEMENT
SERVICES**
Division of State Group Insurance



Humana®

Our service area includes the following: **Florida:** Alachua, Baker, Bay, Bradford, Broward, Charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Duval, Escambia, Flagler, Glades, Hardee, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia, Walton.



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

Find out more about the Humana Group Medicare Advantage HMO 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 HMO 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 HMO 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 HMO 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
1-800-555-7997 for questions
(TTY/TDD: 711)

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

Or visit our website:
<https://your.Humana.com/sof>



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

\$1,000 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; OTC Drugs and Supplies; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Uniform Flexibility Non-Emergency Medical Transportation; 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.



Covered Medical Benefits

IN-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.

\$100 per admit

OUTPATIENT HOSPITAL COVERAGE

Diagnostic colonoscopy \$0 copay

Diagnostic mammography \$10 copay

Observation services \$0 copay

Surgery services \$0 copay

AMBULATORY SURGICAL CENTER

Diagnostic colonoscopy \$0 copay

Surgery services \$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

DOCTOR OFFICE VISITS

Primary care provider (PCP) \$0 copay

Specialists \$10 copay

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

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

- Immunizations
 - Medicare diabetes prevention program (MDPP)
- Covered at no cost**

Any additional preventative services approved by Medicare during the contract year will be covered.

EMERGENCY CARE

Emergency room

\$65 copay for Medicare-covered emergency room visit(s)

If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Urgently needed services

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** copay
- Urgent care center **\$5** 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
- Specialist's office **\$10** copay
- Freestanding radiological facility **\$10** copay
- Outpatient Hospital **\$10** copay

Diagnostic mammography

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** copay
- Freestanding radiological facility **\$0** copay
- Outpatient Hospital **\$10** copay

Diagnostic procedures and tests

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** 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

- Urgent care center **\$5** copay
- Freestanding radiological facility **\$0** copay
- Outpatient Hospital **\$10** copay

EKG screening

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$0** copay
- Freestanding radiological facility **\$0** copay
- Outpatient Hospital **\$0** copay

Lab services

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$0** copay
- Urgent care center **\$0** copay
- Freestanding laboratory **\$0** copay
- Outpatient Hospital **\$0** copay

Nuclear medicine services

- Freestanding radiological facility **\$10** copay
- Outpatient Hospital **\$10** copay

Outpatient x-rays

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** copay
- Urgent care center **\$5** copay
- Freestanding radiological facility **\$0** copay
- Outpatient Hospital **\$10** copay

Radiation therapy

- Specialist's office **\$10** copay
- Freestanding radiological facility **\$10** copay
- Outpatient Hospital **\$10** copay

HEARING SERVICES

- **Medicare-covered hearing: diagnostic hearing and balance exams** **\$10** copay

Routine hearing

HearUSA provider must be used. Contact Customer Service to locate a provider.

\$0 copay for fitting/evaluation, routine hearing exams up to 1 per year.
\$500 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.
 Note: Includes 1 month battery supply and 2 year warranty.

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

DENTAL SERVICES

Medicare-covered dental	\$10 copay
Routine dental	0% of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. 0% of the cost for 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 emergency diagnostic exam, intraoral x-rays up to 1 per year. 0% of the cost for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. 0% of the cost for periodontal maintenance up to 4 per year. 0% of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/analgesia) with covered service up to as needed with covered codes per year. 20% of the cost for amalgam and/or composite filling, emergency treatment for pain up to 2 per year. 20% of the cost for simple or surgical extraction up to unlimited per year. 50% of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. 50% of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. 50% of the cost for complete dentures, partial dentures up to 1 set(s) every 5 years. 50% of the cost for adjustments to dentures, denture rebase, denture reline, denture repair, root canal or retreatment, tissue conditioning up to 1 per year. 50% of the cost for crown, oral surgery up to 2 per year. 50% of the cost for other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime. \$1,000 maximum benefit coverage amount per year for all preventive and comprehensive benefits.

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**.

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).

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

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

VISION SERVICES

Medicare-covered vision services **\$10** copay

Medicare-covered diabetic eye exam (1 per year) **\$0** copay

Medicare-covered glaucoma screening (1 per year) **\$0** copay

Medicare-covered eyewear (post-cataract) **\$0** copay

Routine vision **\$0** copay for routine exam (includes refraction) up to 1 per year.

EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.

MENTAL HEALTH SERVICES

Inpatient **\$100** per admit

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.

Partial Hospitalization **\$0** copay

Intensive Outpatient Services **\$0** copay

Outpatient group and individual therapy visits

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** copay
- Urgent care **\$5** copay
- Outpatient Hospital **\$10** 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

SKILLED NURSING FACILITY (SNF)

This plan covers up to 100 days in a SNF. **\$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

TRANSPORTATION

Routine Transportation **\$0** copay for plan approved location up to 50 one-way trip(s) per year.

Uniform 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 offers unlimited miles per trip.

MEDICARE PART B PRESCRIPTION DRUGS

Chemotherapy drugs

- Specialist's office **\$0** copay
- Outpatient Hospital **\$0** copay

Medicare Part B covered drugs

- Primary care provider (PCP) **20%** of the cost
- Specialist's office **20%** of the cost
- Outpatient Hospital **20%** of the cost
- Pharmacy **0%** of the cost

Medicare Part B insulin drugs

- Primary care provider (PCP) **20%** of the cost
- Specialist's office **20%** of the cost
- Outpatient Hospital **20%** of the cost
- Pharmacy **0%** of the cost

You will pay no more than \$35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.

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

ACUPUNCTURE SERVICES

Medicare-covered acupuncture visit(s) for chronic low back pain **\$10** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.

ALLERGY

Allergy shots & serum

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$0** copay

CHIROPRACTIC SERVICES

Medicare-covered chiropractic visit(s) **\$10** copay

DIABETES SERVICES AND SUPPLIES

Continuous glucose monitor (CGM)

- Durable medical equipment provider **0%** of the cost
- Pharmacy **0%** of the cost

Diabetes management training

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$0** copay
- Outpatient hospital **\$0** copay

Diabetes monitoring supplies

- Durable medical equipment provider **\$10** copay
- Pharmacy **\$10** copay
- Preferred diabetic supplier **\$0** copay

Diabetes screening

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$0** copay

FOOT CARE (PODIATRY)

Medicare-covered foot care **\$10** copay

Routine foot care **\$10** copay for routine podiatry visits up to unlimited visit(s) per year.

HOME HEALTH CARE

\$0 copay

HOSPICE

You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.

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Covered Medical Benefits

IN-NETWORK

MEDICAL EQUIPMENT/SUPPLIES

Durable medical equipment

- Durable medical equipment provider **0%** of the cost
- Pharmacy **0%** of the cost

Medical supplies (includes but not limited to: catheters, IV set-up and supplies)

- Medical supply provider **0%** of the cost
- Pharmacy **0%** of the cost

Prosthetics (artificial limbs or braces)

- Prosthetics provider **0%** of the cost

OUTPATIENT SUBSTANCE ABUSE

Outpatient group and individual substance abuse treatment visits

- Primary care provider (PCP) **\$0** copay
- Specialist's office **\$10** copay
- Urgent care **\$5** copay
- Outpatient hospital **\$10** copay

OVER-THE-COUNTER ITEMS

\$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused amount expires at the end of the quarter.

REHABILITATION SERVICES

Audiology Therapy

- Specialist's office **\$10** copay
- Comprehensive outpatient rehab facility **\$5** copay
- Outpatient hospital **\$5** copay

Cardiac rehabilitation

- Specialist's office **\$10** copay
- Outpatient hospital **\$5** copay

Occupational therapy

- Specialist's office **\$10** copay
- Comprehensive outpatient rehab facility **\$5** copay
- Outpatient hospital **\$5** copay

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Covered Medical Benefits

IN-NETWORK

Physical therapy

- Specialist's office \$10 copay
- Comprehensive outpatient rehab facility \$5 copay
- Outpatient hospital \$5 copay

Pulmonary rehabilitation

- Specialist's office \$10 copay
- Comprehensive outpatient rehab facility \$5 copay
- Outpatient hospital \$5 copay

Speech therapy

- Specialist's office \$10 copay
- Comprehensive outpatient rehab facility \$5 copay
- Outpatient hospital \$5 copay

RENAL DIALYSIS

Renal dialysis services

- Dialysis center \$0 copay
- Outpatient hospital \$0 copay

Kidney disease education services

- Primary care provider (PCP) \$0 copay
- Specialist's office \$0 copay
- Outpatient hospital \$0 copay

HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)

Primary care provider (PCP) \$0 copay

Specialist \$10 copay

Urgent care services \$0 copay

Substance abuse or behavioral health services \$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).



Additional Benefits

FITNESS AND WELLNESS

Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

POST-DISCHARGE SERVICES

\$0 copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay:

- 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 to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle.

Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

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).

This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines. At the very top, there is a dashed line. Below it are several solid horizontal lines spaced evenly apart, providing a guide for letter height and placement. The entire page is otherwise empty, with no text or other markings.

[illegible]

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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)**.

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

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **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]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge 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 linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિ:શુલ્ક 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)**.

हिन्दी [Hindi]: नि:शुल्क 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)**.

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

This notice is available at <https://www.humana.com/legal/multi-language-support>.

GHHNOA2025HUM_0425

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 សេវាកម្មជំនួយប្រភេទផ្សេងៗដល់សហគមន៍កម្ពុជា។ 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]: ມີການບໍລິການດ້ານພາສາ, ຊ່ວຍກ່ອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ໄດ້.
ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjì' bee adahodoonílgíí diné bich'í' anídahazt'i'í, dóó łahgo át'éego bee hada' dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjì' hodílnih **877-320-1235 (TTY: 711)**.

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

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

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ 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 serbisyon pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

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

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

አማርኛ [Amharic]: ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsàà [Bassa]: Wuḍu-xwíníín-mú-zà-zà kùà, Hwòdǒ-fóhó-nyo, kè nyo-boŭn-po-kà bɛ bɛ nyuɛɛ se wíqí pɛɛ-pɛɛ dò kò. **877-320-1235 (TTY: 711)** dá.

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

Òyìnbó [Yoruba]: Àwọn isẹ àtìlẹ̀hìn ìrànlọ̀wọ̀ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wọ̀tó. Pe **877-320-1235 (TTY: 711)**.

नेपाली [Nepali]: भाषासम्बन्धी निःशुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।



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