2027

Summary of Benefits

Humana Group Medicare Advantage HMO Plan
HMO 076/609

State of Florida



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.

Plan name:

Humana Group Medicare Advantage HMO plan

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**

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.

A healthy partnership

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

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; 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.

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.*

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**

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	IN-NETWORK
• Immunizations • Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	**Covered at no cost**
EMERGENCY CARE	
Emergency room 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.	**$65** copay for Medicare-covered emergency room visit(s)
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

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Covered Medical Benefits

	IN-NETWORK
• Specialist's office	**$10** copay
• 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

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	IN-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. **$500** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear 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.
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

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IN-NETWORK

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).

The Mandatory Supplemental Dental benefits are provided through the HumanaDental. 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 **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.
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.	**$100** per admit
Partial Hospitalization	**$0** copay
Intensive Outpatient Services	**$0** copay

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Covered Medical Benefits

	IN-NETWORK
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
SKILLED NURSING FACILITY (SNF)	
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100
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.
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 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

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	IN-NETWORK
• 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.	
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
• Preferred Pharmacy	**$0** copay
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.

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Covered Medical Benefits

	IN-NETWORK
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.	
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

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	IN-NETWORK
• Outpatient hospital	**$5** copay
Occupational therapy	
• Specialist's office	**$10** copay
• Comprehensive outpatient rehab facility	**$5** copay
• Outpatient hospital	**$5** copay
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

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Additional Benefits

	IN-NETWORK
FITNESS AND WELLNESS	
Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.	**$0** copay
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

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Additional Benefits

	IN-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.
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
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

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Notes

Notes

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)**.

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العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسّيق 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:

Bǎsóò [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fónɔ́-nyɔ̀,, kè nyɔ-bɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ̀. Ɓá **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 fòma 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)**.

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

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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 សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ 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 ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

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

नेपाली [Nepali]: नि:शुल्क 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]: ਮੁਫ਼ਤ 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 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.

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

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 iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó lọ́fẹ̀ẹ́.
Pe **877-320-1235 (TTY: 711)**.

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