2020

Summary of Benefits

Optional Supplemental Benefits

HumanaChoice® H5216-047 (PPO)

Washington/Oregon
Select Counties in Washington and Oregon

Humana®

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

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Our service area includes the following county/counties in Oregon: Crook, Deschutes, Jefferson Washington: Clark, Cowlitz, Island, King, Kitsap, Kittitas, Skagit, Snohomish, Spokane, Walla Walla, Whatcom.

Let's talk about HumanaChoice H5216-047 (PPO)

Find out more about the HumanaChoice H5216-047 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5216-047 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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, ask us for the "Evidence of Coverage".

To be eligible

To join HumanaChoice H5216-047 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5216-047 (PPO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare.

More about HumanaChoice H5216-047 (PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). HumanaChoice H5216-047 (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

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

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	**$101** If you receive "Extra Help" from Medicare, depending on the level of "Extra Help" you receive, the plan premium may be reduced to **$0**.	
Medical deductible	This plan does not have a deductible.	
Pharmacy (Part D) deductible	**$320** for Tier 3, Tier 4, Tier 5.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$6,700** in-network **$10,000** combined in- and out-of-network	**$10,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$300 copay per day for days 1-5 **$0** copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay.	**50%** of the cost
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**20%** of the cost	**50%** of the cost
Outpatient surgery at ambulatory surgical center	**20%** of the cost	**50%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$10** copay	**50%** of the cost
Specialists	**$45** copay	**50%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program	**$0** or **50%** of the cost, depending on the service and where service is provided

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	Any additional preventive services approved by Medicare during the contract year will be covered.	
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$90** copay	**$90** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$25** copay at an urgent care center	**50%** of the cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic mammography	**$45** or **20%** of the cost	**50%** of the cost
Diagnostic radiology	**$180** to **$300** copay	**50%** of the cost
Lab services	**$0** to **$40** copay	**50%** of the cost
Diagnostic tests and procedures	**$0** to **$45** copay	**50%** of the cost
Outpatient X-rays	**$10** to **$15** copay	**50%** of the cost
Radiation therapy	**20%** of the cost	**50%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$45** copay	**50%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER941** • **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for Premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty.	**HER941** • **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for Advanced level hearing aid up to 1 per ear per year. • **$999** copayment for Premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • TruHearing provider must be used for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare-covered dental	**$45** copay	**50%** of the cost
VISION SERVICES		
Medicare-covered vision services	**$45** copay	**50%** of the cost
Diabetic Eye Exam	**$0** copay	**50%** of the cost
Glaucoma screening	**$0** copay	**50%** of the cost
Eyewear (post-cataract)	**$0** copay	**50%** of the cost

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision The provider locator for routine vision can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Vision coverage through Medicare Advantage plans.	**VIS751** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating.	**VIS751** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$100** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$300** copay per day for days 1-5 **$0** copay per day for days 6-90	**50%** of the cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$55** copay or **20%** of the cost	**50%** of the cost
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$178** copay per day for days 21-60 **$0** copay per day for days 61-100	**50%** of the cost for days 1-100
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$40** or **20%** of the cost	**50%** of the cost

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
AMBULANCE		
Ambulance (ground)	**$265** per date of service	**$265** per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**50%** of the cost
Other part B drugs	**20%** of the cost	**50%** of the cost
PRESCRIPTION DRUGS		

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan has a **$320** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $320. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Preferred cost-sharing

Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail order** Humana Pharmacy®	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$4	$12	$4	$0
Tier 2: Generic	$15	$45	$15	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$100	$300	$100	$290
Tier 5: Specialty Tier	27%	N/A	27%	N/A

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Standard cost-sharing				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order** Walmart Mail	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$10	$30	$10	$30
Tier 2: Generic	$20	$60	$20	$60
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	$100	$300	$100	$300
Tier 5: Specialty Tier	27%	N/A	27%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug List to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **$0** or **$89** depending on your level of Extra Help (for Tier 3, Tier 4, Tier 5). If your deductible is **$89**, you pay the full cost of these drugs until you reach **$89**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs	**30-day supply**	**90-day supply**
(including brand drugs treated as generic), either:	**$0** copay; or **$1.30** copay; or **$3.60** copay ; or **15%** of the cost	**$0** copay; or **$1.30** copay; or **$3.60** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$3.90** copay; or **$8.95** copay ; or **15%** of the cost	**$0** copay; or **$3.90** copay; or **$8.95** copay ; or **15%** of the cost

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days' Supply Available

Unless otherwise specified, you can get your Part D drug in the following days' supply amounts:
- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your costs total **$6,350** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, you pay the greater of:
- **5%** of the cost, or
- **$3.60** copay for generic (including brand drugs treated as generic) and a **$8.95** copayment for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$45** copay	**50%** of the cost
Medicare-covered chiropractic services	**$20** copay	**50%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**25%** of the cost
Medical Supplies	**20%** of the cost	**50%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**50%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**50%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$40** or **20%** of the cost	**50%** of the cost

Cardiac rehabilitation	**$10** copay	**50%** of the cost
Pulmonary rehabilitation	**$10** copay	**50%** of the cost

H5216047000

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Travel Coverage

As a member of a Humana PPO, you have the benefit to use Humana's network of providers across the U.S. (not available in all counties). If you are visiting another Humana PPO service area, simply access a Humana network provider to receive your in-network level of benefits for up to twelve consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations. Visit **Humana.com** or contact Customer Care on the back of your ID card if you need help finding an in-network provider.

Well Dine Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

Up to **$30** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Rewards and Incentives

Rewards for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$37.90

MyOption Dental - High DEN838

Includes benefits for preventive, basic, and major services at both in-network (HumanaDental Medicare network) and out-of-network dentists. These benefits have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug list** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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2020

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HumanaChoice®
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Humana®

My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

The information in this booklet will tell you about the benefits you can add to your plan. You can add these extra benefits when you sign up for your Medicare Advantage plan. You can also add these benefits after Medicare open enrollment ends on December 7 by contacting your agent or calling OSB sales at 1-888-413-7026. OSB sales is available from 8 a.m. – 8 p.m. local time, seven days a week October 1 – March 31, and Monday through Friday April 1 – September 30.

MyOption℠ Dental – High (DEN838)

The MyOption℠ Dental – High benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	**$37.90**		
Maximum Benefit	Humana pays up to **$2,000** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services			
Periodic oral examinations	**0%**	**50%**	Two per year
Emergency diagnostic exam	**0%**	**50%**	
Periodontal exam	**0%**	**50%**	One procedure every three years
Comprehensive oral evaluation	**0%**	**50%**	
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Fluoride treatment	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One set per year
Intraoral X-ray	**0%**	**50%**	One per year
Panoramic or diagnostic X-ray	**0%**	**50%**	One every five years
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**50%**	**55%**	Two per year
Composite resin restorations (white fillings)	**50%**	**55%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Extractions (pulling teeth), simple or surgical	**50%**	**55%**	Two per year
Recementation – Crown	**50%**	**55%**	One procedure every five years
Emergency treatment for pain	**50%**	**55%**	Two per year
Anesthesia	**0%**	**50%**	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Crowns	**70%**	**75%**	Two per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure for each quadrant every three years
Periodontal Maintenance	**70%**	**75%**	Four procedures per calendar year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you can't be billed more than that rate.

**Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a Doctor > From the Search Type drop down select Dental > Under Coverage Type select All Dental Networks > Enter zip code > From the Network drop down select HumanaDental Medicare.**

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Notes

Notes

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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