

# 2019 Summary of Benefits

Allina Health Aetna Medicare Discover Elite (PPO)

H3219, Plan 004

**This is a summary of services covered by Allina Health Aetna Medicare Discover Elite (PPO)**

**January 1, 2019 - December 31, 2019**

**Allina Health Aetna Medicare Discover Elite (PPO)** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. The plan's "Evidence of Coverage" provides a complete list of services we cover. The "Evidence of Coverage" is available on our website or you may call us to request a copy.

## Contact us

Current members call the number on your ID card.

For more information, please call us at the phone number below or visit us at <https://www.AllinaHealthAetnaMedicare.com>.

If you are not a member of this plan, call toll-free 1-833-206-8764 (TTY users should call 711). From October 1 to March 31, you can call us 7 days a week from 8:00 am to 8:00 pm local time. From April 1 to September 30, you can call us Monday through Friday from 8:00 am to 8:00 pm local time.

To join Allina Health Aetna Medicare Discover Elite (PPO), you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in **Minnesota**: Anoka, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Nicollet, Ramsey, Scott, Washington, Wright.

H3219-004-1 A

## Things to Know

This is a Medicare Advantage plan which **REPLACES** your Original Medicare coverage. This plan covers all services covered under Original Medicare's Part A and Part B and even provides additional coverage.

	<b>Original Medicare</b>	<b>This Plan</b>
Covers your Medicare Part A and Part B services	√	√
Offers coverage beyond Medicare Part A and Part B	X	√
Prescription drug coverage	X	√
Allows you to see a specialist without a referral from your PCP	√	√ (Generally you pay less if you use a network doctor)
Protects your out-of-pocket costs by limiting what you pay for medical care	X	√
Fitness benefit through SilverSneakers	X	√
Nurse Advice Hotline 24/7	X	√

## Monthly Plan Premium: \$147

You must continue to pay your Medicare Part B premium.

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network	What You Should Know
<b>Deductible(s)</b>	This plan does not have a deductible.		
<b>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</b>	\$3,000 for in-network services annually	\$4,500 for in and out-of-network services combined.	The most you pay for copays, coinsurance and other costs for medical services for the year.
<b>Inpatient Hospital Coverage</b>	\$250 per stay Our plan covers an unlimited number of days for an inpatient hospital stay.	20% per stay	Prior authorization may be required.
<b>Outpatient Hospital coverage</b>	Outpatient hospital observation services: \$100 copay  Freestanding ambulatory surgery center: \$50 copay  Outpatient hospital surgery: \$100 copay	Outpatient hospital observation services: 20% of the total cost  Outpatient surgery (Freestanding ambulatory surgical center or outpatient hospital): 20% of the total cost	Prior authorization may be required.
<b>Doctor Visits</b>			
<ul style="list-style-type: none"> <li>• <b>Primary Care Physician (PCP)</b></li> </ul>	\$0 copay	20% of the total cost	
<ul style="list-style-type: none"> <li>• <b>Specialists</b></li> </ul>	\$10 copay	20% of the total cost	
<b>Preventive Care</b>	\$0 copay	0% - 20% of the total cost	Any additional preventive services approved by Medicare during the

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network	What You Should Know
			<p>contract year will be covered.</p> <p>Lower cost sharing for Medicare - covered immunizations out-of-network.</p> <p>Higher cost sharing for all other preventive benefits out-of-network.</p>
<b>Emergency Care</b>	<p>\$90 copay per visit</p> <p>\$90 copay for worldwide coverage (emergency care outside of the United States)</p>		<p>If you are directly admitted to the hospital, you do not have to pay your share of the cost for emergency care.</p>
<b>Urgently Needed Services</b>	<p>\$0 - \$65 copay for each urgent care facility visit</p> <p>\$90 copay for urgent care worldwide (i.e. outside of the United States)</p>		<p>Lower cost sharing for services provided by your primary care physician in his/her office. Higher cost sharing for services performed by a provider other than your primary care physician.</p> <p>Cost sharing for urgent care is <u>not</u> waived if you are admitted to the hospital.</p>
<b>Diagnostic Services/Labs/Imaging</b>			<p>Prior authorization or physician's order may be required.</p>
<ul style="list-style-type: none"> <li>• <b>Diagnostic radiology</b></li> </ul>	\$50 copay	20% of the total cost	

<b>Benefits</b>	<b>Allina Health Aetna Medicare Discover Elite (PPO) In Network</b>	<b>Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network</b>	<b>What You Should Know</b>
<b>services (e.g., MRI)</b>			
• <b>Lab services</b>	\$0 copay	20% of the total cost	
• <b>Diagnostic tests and procedures</b>	\$0 copay	20% of the total cost	
• <b>Outpatient x-rays</b>	\$0 copay	20% of the total cost	
<b>Hearing Services</b>			
• <b>Medicare-covered hearing exam</b>	\$10 copay	20% of the total cost	
• <b>Routine hearing exam</b> (one exam every year)	\$0 copay	20% of the total cost	
• <b>Hearing aids</b>	<p>Covered (See the Evidence of Coverage for details).</p> <p>Our plan offers a hearing aid reimbursement of up to \$1,500 (both ears combined) for hearing aids every year.</p> <p>Any licensed hearing provider may provide services. You pay the provider for services, submit an itemized billing statement showing proof of payment to our plan and you will be reimbursed.</p>	Covered (See the Evidence of Coverage for details).	You are responsible for any amount over the hearing aid coverage limit.
<b>Dental Services</b>			
<b>Dental Services</b>	Any licensed dental provider may provide services. You pay the provider for services, submit an itemized billing statement showing		

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network	What You Should Know
	proof of payment to our plan and you will be reimbursed.		
	Our plan offers a dental reimbursement of up to \$2,000 for preventive and comprehensive dental services every year.		You are responsible for any amount over the dental coverage limit.
<ul style="list-style-type: none"> <li>• <b>Oral exam &amp; cleaning</b></li> </ul>	Covered (See the <i>Evidence of Coverage</i> for details).	Covered (See the <i>Evidence of Coverage</i> for details).	
<ul style="list-style-type: none"> <li>• <b>Fillings</b></li> </ul>	Covered (See the <i>Evidence of Coverage</i> for details).	Covered (See the <i>Evidence of Coverage</i> for details).	
<b>Vision Services</b>			
<ul style="list-style-type: none"> <li>• <b>Medicare-covered eye exams</b></li> </ul>	\$0 copay for glaucoma screenings  \$0 copay for diabetic eye exams  \$10 copay for other exams to diagnose and treat diseases and conditions of the eye	20% of the total cost	
<ul style="list-style-type: none"> <li>• <b>Routine eye exam</b> (one exam every year)</li> </ul>	\$0 copay	20% of the total cost	
<ul style="list-style-type: none"> <li>• <b>Contacts and Eyeglasses (frames and lenses and upgrades)</b></li> </ul>	Covered (See the <i>Evidence of Coverage</i> for details).	Covered (See the <i>Evidence of Coverage</i> for details).	
	Our plan offers an eyewear reimbursement of up to \$300 for contacts and eyeglasses every year (See the <i>Evidence of Coverage</i> for details.)		You are responsible for any amount over the eyewear coverage limit.

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network	What You Should Know
	Any licensed eyewear provider may provide services. You pay the provider for services, submit an itemized billing statement showing proof of payment to our plan and you will be reimbursed.		
<ul style="list-style-type: none"> <li>• <b>Eyeglasses or contact lenses after cataract surgery</b></li> </ul>	\$0 copay	20% of the total cost	
<b>Mental Health Services</b>			Prior authorization may be required.
<ul style="list-style-type: none"> <li>• <b>Inpatient psychiatric hospital stay</b></li> </ul>	\$250 per stay	20% per stay	
<ul style="list-style-type: none"> <li>• <b>Outpatient group therapy visit</b></li> </ul>	\$40 copay	20% of the total cost	
<ul style="list-style-type: none"> <li>• <b>Outpatient individual therapy visit</b></li> </ul>	\$40 copay	20% of the total cost	
<b>Skilled Nursing Facility (SNF)</b>	\$0 per day, days 1-20; \$75 per day, days 21-100	20% per stay	Our plan covers up to 100 days in a SNF. Prior authorization may be required.
<b>Physical therapy</b>	\$10 copay	20% of the total cost	Prior authorization may be required.
<b>Ambulance (one-way trip)</b>	Ground Ambulance: \$250 copay  Air Ambulance: \$250 copay	Ground Ambulance: \$250 copay  Air Ambulance: \$250 copay	Prior authorization is required for non-emergency fixed wing aircraft transportation.
<b>Transportation</b>	Not Covered	Not Covered	

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of- Network	What You Should Know
<b>Medicare Part B Drugs</b>	20% of the total cost for chemotherapy drugs  20% of the total cost for other Part B drugs	20% of the total cost	Prior authorization may be required.

**Outpatient Prescription Drugs**

**Prescription Drug Coverage**

If you qualify for the Low-Income Subsidy (also called “Extra Help”), you may not pay the amounts listed in the table below for your Part D prescription drugs. The exact amount you pay may vary depending on the amount of Extra Help you get and the pharmacy you choose.

If you do not qualify for the Low-Income Subsidy, you will pay the amounts in the table below.

**Deductible** This plan does not have a pharmacy deductible.

**Initial Coverage Limit (ICL)** - total amount you and the plan pay for prescription drugs before you enter the coverage gap: \$3,820

**True Out-of-Pocket Threshold Amount (TrOOP)** – total amount you pay before reaching the catastrophic coverage level: \$5,100



<b>Formulary: B2AL</b>	<b>Preferred Retail Rx 30-day supply</b>	<b>Standard Retail Rx 30-day supply</b>	<b>Preferred Retail 90-day supply</b>	<b>Preferred Mail Order 90-day supply</b>	<b>Standard Retail/Mail Order 90-day supply</b>
Tier 1: Preferred Generic	\$2	\$15	\$0	\$0	\$45
Tier 2: Generic	\$5	\$20	\$15	\$10	\$60
Tier 3: Preferred Brand	\$47	\$47	\$141	\$136	\$141
Tier 4: Non-Preferred Drug	\$100	\$100	\$300	\$300	\$300
Tier 5: Specialty	33%	33%	N/A	N/A	N/A

The lower costs advertised in our plan materials for preferred pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, members please call the number on your ID card, non-members please call 1-833-206-8764 (TTY: 711) or consult the online pharmacy directory at <https://www.AllinaHealthAetnaMedicare.com/findprovider>.

Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. Members who get “Extra Help” are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

### **Additional Gap Coverage**

Our plan offers some drug coverage in the Coverage Gap Stage.

Cost sharing for a 30-day supply at a network retail pharmacy that offers preferred cost sharing:

- Tier 1: \$2
- Tier 2: \$5

Cost sharing for a 30-day supply at a network retail pharmacy that offers standard cost sharing:

- Tier 1: \$15
- Tier 2: \$20

For all other formulary drugs, after you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total \$5,100, which is the end of the coverage gap.

### Catastrophic Coverage

After your total out-of-pocket costs reach \$5,100, you pay the greater of:

- 5% of the cost of the drug
- \$3.40 for a generic drug or a drug that is treated like a generic and \$8.50 for all other drugs

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of-Network	What You Should Know
<b>Other Information and Benefits</b>			
<b>Referrals</b>	You don't need a referral from a PCP.		
<b>Travel Network</b>	You may receive all plan covered services at in-network cost-sharing when you see an Aetna Medicare network provider in the following states: AZ, FL, GA, NC and SC. In most cases, non-urgent/non-emergent care you receive from an out-of-network provider (a provider who is not an Aetna Medicare provider), your share of the costs for your covered services may be higher.		
<b>Additional Services and Support</b>	Resources For Living <sup>SM</sup> helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities and more.		
<b>Acupuncture</b> (twelve (12) visits every year)	\$20 copay	20% of the total cost	Acupuncture benefit available through Allina Health Aetna Medicare participating providers. Members can use acupuncture care as a holistic approach to improving certain medical conditions.

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of-Network	What You Should Know
<b>Chiropractic Care</b>	Medicare covered services: \$20 copay  Routine chiropractic services: \$20 copay (twelve (12) visits every year)	Medicare covered services: 20% of the total cost  Routine chiropractic services: 20% of the total cost	Medicare coverage is limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).  Prior authorization may be required.
<b>Dialysis</b>	20% of the total cost	20% of the total cost	Prior authorization may be required.
<b>Foot Care (podiatry services)</b>			
<ul style="list-style-type: none"> <li>• Medicare-covered foot exams and treatment</li> </ul>	\$10 copay	20% of the total cost	
<b>Home Health Care</b>	\$0 copay	20% of the total cost	Prior authorization may be required.
<b>Hospice</b>	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.		Please see the <i>Evidence of Coverage</i> for more information about hospice care and coverage.
<b>Meals</b>	\$0 copay  Our plan covers up to 14 home delivered meals over a 7 day period after an inpatient hospital discharge.		
<b>Medical Equipment/Supplies</b>			Prior authorization may be required.
<ul style="list-style-type: none"> <li>• Durable medical equipment (DME)</li> </ul>	20% of the total cost	20% of the total cost	

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of-Network	What You Should Know
(wheelchair, oxygen, etc.)			
<ul style="list-style-type: none"> <li>• <b>Prosthetics (e.g., braces, artificial limbs)</b></li> </ul>	20% of the total cost	20% of the total cost	
<ul style="list-style-type: none"> <li>• <b>Diabetic supplies</b></li> </ul>	<p>We exclusively cover blood glucose monitors and diabetic test strips manufactured by OneTouch / LifeScan, such as OneTouch Verio®, OneTouch Ultra®, OneTouch UltraMini® systems, test strips and supplies.</p>		<p>Prior authorization is required for blood glucose monitors in excess of one monitor per year and test strips in excess of 100 per 30 days. Test strips and monitors from a manufacturer other than One Touch/Lifescan are not covered, except when medically necessary and with prior authorization</p>
	0% - 20% of the total cost	0% - 20% of the total cost	<p>Higher cost-share applies for non-OneTouch / LifeScan diabetic supplies, even with a medical exception.</p>
<p><b>Outpatient Substance Abuse</b></p>	<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>	20% of the total cost	<p>Prior authorization may be required.</p>
<p><b>Over-the-counter items (OTC)</b></p>	<p>Plan pays up to a \$45 maximum benefit every month for OTC items.</p> <p>OTC Vendor: CVS</p>		<p>Eligible items are listed in the OTC catalog. Items that are <b>not</b> listed in the OTC catalog are not</p>

Benefits	Allina Health Aetna Medicare Discover Elite (PPO) In Network	Allina Health Aetna Medicare Discover Elite (PPO) Out-of-Network	What You Should Know
			covered under the OTC benefit.
<b>Wellness Program (e.g. fitness)</b>	<p>Free membership at participating SilverSneakers fitness facilities. Also access to online wellness related tools, planners, newsletters and classes.</p> <p>For more information about SilverSneakers® visit <a href="https://www.silversneakers.com">https://www.silversneakers.com</a>.</p> <p>At-home fitness kits are available if you do not reside near a participating club or prefer to exercise at home.</p> <p>The nursing hotline provides members with a toll-free telephone number to speak with a registered nurse at any time to discuss medical issues or health and wellness topics, 24 hours a day, 7 days a week.</p>		
<b>Healthy Rewards Program</b>	<p>We offer a program where you can earn gift cards for completing certain health care activities. All members of the plan are eligible to participate. To earn your rewards, you must complete qualifying health screenings and immunizations.</p>		

## **Compare our plan to Medicare**

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.

Allina Health Aetna Medicare is a PPO plan with a Medicare contract.

This information is not a complete description of benefits. Call our plan for more information. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. Members who get “Extra Help” are not required to fill prescriptions at preferred network pharmacies in order to get Low Income Subsidy (LIS) copays.

You can see our plan’s provider directory at our website at <https://www.AllinaHealthAetnaMedicare.com/findprovider>.

Members in our PPO plans can go to doctors, specialists or hospitals in- or out-of-network. With the exception of emergency or urgent care, it may cost more to get care from out-of-network providers.

Out-of-network/non-contracted providers are under no obligation to treat Allina Health Aetna Medicare 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.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at <https://www.AllinaHealthAetnaMedicare.com/formulary>.

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We comply with applicable Federal civil rights laws and do not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. We provide free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, contact the phone number listed on this document. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can file a grievance in writing with our Grievance Department (write to the address listed in your Evidence of Coverage) or by phone by calling the phone number listed on this document (TTY: 711). You can also file a grievance by contacting our Civil Rights Coordinator by phone at 1-855-348-1369, by email at MedicareCRCoordinator@aetna.com. You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

## TTY: 711

If you speak a language other than English, free language assistance services are available. Visit our website or call the phone number listed in this document. (English)

Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento. (Spanish)

如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。(Traditional Chinese)

Kung hindi Ingles ang wikang inyong sinasalita, may maaari kayong kuning mga libreng serbisyo ng tulong sa wika. Bisitahin ang aming website o tawagan ang numero ng telepono na nakalista sa dokumentong ito. (Tagalog)

Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique gratuits vous sont proposés. Visitez notre site Internet ou appelez le numéro indiqué dans ce document. (French)

Nếu quý vị nói một ngôn ngữ khác với Tiếng Anh, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí. Xin vào trang mạng của chúng tôi hoặc gọi số điện thoại ghi trong tài liệu này. (Vietnamese)

Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Besuchen Sie unsere Website oder rufen Sie die Telefonnummer in diesem Dokument an. (German)

영어가 아닌 언어를 쓰시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 저희 웹사이트를 방문하시거나 본 문서에 기재된 전화번호로 연락해 주십시오. (Korean)

Если вы не владеете английским и говорите на другом языке, вам могут предоставить бесплатную языковую помощь. Посетите наш веб-сайт или позвоните по номеру, указанному в данном документе. (Russian)

إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متاحة. تفضل بزيارة موقعنا على الويب أو اتصل برقم الهاتف المدرج في هذا المستند. (Arabic)

अगर आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। हमारी वेबसाइट पर जाएं या इस दस्तावेज़ में दिए गए फोन नंबर पर कॉल करें। (Hindi)

Nel caso Lei parlasse una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Visiti il nostro sito web oppure chiami il numero di telefono elencato in questo documento. (Italian)

Caso você seja falante de um idioma diferente do inglês, serviços gratuitos de assistência a idiomas estão disponíveis. Acesse nosso site ou ligue para o número de telefone presente neste documento. (Portuguese)

Si ou pale yon lòt lang ki pa Anglè, wap jwenn sèvis asistans pou lang gratis ki disponib. Vizite sitwèb nou an oswa rele nan nimewo telefòn ki make nan dokiman sa a. (Haitian Creole)

Jeżeli nie posługują się Państwo językiem angielskim, dostępne są bezpłatne usługi wsparcia językowego. Proszę odwiedzić naszą witrynę lub zadzwonić pod numer podany w niniejszym dokumencie. (Polish)

英語をお話しにならない方は、無料の言語支援サービスを受けることができます。弊社のウェブサイトアクセスするか、または本書に記載の電話番号にお問い合わせください。(Japanese)

Nëse nuk flisni gjuhën angleze, shërbime ndihmëse gjuhësore pa pagesë janë në dispozicionin tuaj. Vizitoni faqen tonë në internet ose merrni në telefon numrin e telefonit në këtë dokument. (Albanian)

ከእንግሊዝኛ ሌላ ቋንቋ የሚናገሩ ከሆነ ነጻ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይቻላል። የእኛን ድረ-ገጽ ይጎብኙ ወይም በዚህ ስነድ ላይ የተዘረዘረውን ስልክ ቁጥር በመጠቀም ይደውሉ። (Amharic)



Եթե խոսում եք անգլերենից բացի մեկ այլ լեզվով, ապա Ձեզ համար հասանելի են լեզվակապ  
աջակցման անվճար ծառայություններ: Այցելեք մեր վեբ կայքը կամ զանգահարեք այս  
փաստաթղթում նշված հեռախոսահամարով: (Armenian)

যদি আপনি ইংরেজী ব্যতীত অন্য কোনো ভাষায় কথা বলেনতাহলে বিনামূল্যের দোভাষীর পরিষেবা উপলব্ধ আছে।  
আমাদের ওয়েবসাইট দেখুন এবং এই নথিতে তালিকাভুক্ত ফোন নম্বরে ফোন করুন। (Bengali)

បើលោកអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនដោយឥតគិតថ្លៃ។ សូមចូលមើលគេហទំព័ររបស់យើងខ្ញុំ  
ឬហៅទៅកាន់លេខទូរស័ព្ទដែលមានរាយនៅក្នុងឯកសារនេះ។ (Khmer)

Ako govorite neki jezik koji nije engleski, dostupne su besplatne jezičke usluge. Posetite našu internet stranicu  
ili nazovite broj telefona navedenog u ovom dokumentu. (Serbo-Croatian)

Na ye jam thuɔŋdət tənə thoŋ ɛ Dīŋlīth, ke kuɔɔny luilooi ɛ thok ɛ path aa tō thīn. Nem yōt tən internet tēdē ke  
yī cəl akuən cōtmec cī gat thin nē athör du yic. (Dinka)

Als u een andere taal spreekt dan Engels, is er gratis taalondersteuning beschikbaar. Bezoek onze website of bel  
naar het telefoonnummer in dit document. (Dutch)

Εάν ομιλείτε άλλη γλώσσα εκτός της Αγγλικής, υπάρχουν δωρεάν υπηρεσίες στη γλώσσα σας. Επισκεφθείτε  
την ιστοσελίδα μας ή καλέστε τον αριθμό τηλεφώνου που αναγράφεται στο παρόν έγγραφο. (Greek)

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ ઉપલબ્ધ છે. અમારી વેબસાઇટની મુલાકાત લો અથવા દસ્તાવેજમાં  
સૂચીબદ્ધ ક્રમાંકમાં આવેલ ફોન નંબર પર કોલ કરો. (Gujarati)

Yog hais tias koj hais ib hom lus uas tsis yog lus Askiv, muaj cov kev pab cuam txhais lus dawb pub rau koj.  
Mus saib peb lub website los yog hu rau tus xov tooj sau teev tseg nyob rau hauv daim ntawv no. (Hmong)

ຖ້າທ່ານວົ້າພາສານອກເໜືອຈາກອັງກິດ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າແມ່ນມີໃຫ້ທ່ານ.  
ໄປທີ່ເວັບໄຊທ໌ຂອງພວກເຮົາ ຫຼື ໂທຕາມເບີໂທລະສັບທີ່ລະບຸໃນເອກະສານນີ້. (Lao)

Bilagáana bizaad doo bee yáníłti'da dóó saad náána' ła' bee yáníłti'go, ata' hane' t'áá jíík'e bee áká  
i'doolwołígíí hółq̄. Béesh nitsékeesi bee na'ídikid bá haz'ánigi aa'ádíłilíí' éí doodago béesh bee hane'í bee  
nihich'í' hodíłnih díí naaltsos bikáá'íjii'. (Navajo)

Wann du en Schprooch anners as Englisch schwetzsch, Schprooch Hilfe mitaus Koscht iss meeglich. Bsuch  
unsere Website odder ruf die Nummer uff des Document uff. (Pennsylvania Dutch)

اگر به زبان دیگری بجز انگلیسی گفتگو می کنید، کمک زبانی رایگان فراهم می باشد. به وبسایت ما مراجعه نمایید و یا به شماره تلفن که در سند ذیل  
لست شده، تماس بگیرید. (Farsi)

ਜੇ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਸਾਡੀ ਵੈੱਬਸਾਈਟ 'ਤੇ ਜਾ  
ਓ ਜਾਂ ਿਏਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

Dacă vorbiți o altă limbă decât engleza, aveți la dispoziție servicii gratuite de asistență lingvistică. Vizitați site-  
ul nostru sau sunați la numărul de telefon specificat în acest document. (Romanian)

ܠܐܢܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ ܕܥܘܠܡܝܢ  
(Syriac)

หากคุณพูดภาษาอื่นนอกเหนือจากภาษาอังกฤษ สามารถขอรับบริการช่วยเหลือด้านภาษาได้ฟรี เข้าไปที่เว็บไซต์ของเรา  
หรือโทรติดต่อหมายเลขโทรศัพท์ที่แสดงไว้ในเอกสารนี้ (Thai)

Якщо ви не говорите англійською, до ваших послуг безкоштовна служба мовної підтримки. Відвідайте  
наш веб-сайт або зателефонуйте за номером телефону, що зазначений у цьому документі. (Ukrainian)

اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، زبان سے متعلق مدد کی مفت خدمات دستیاب ہیں۔ ہماری ویب سائٹ ملاحظہ کریں  
یا اس دستاویز میں درج فون نمبر پر کال کریں۔ (Urdu)

אויב איר רעדט א שפראך אויסער ענגליש, זענען שפראך הילף סערוויסעס אוועילעבל. באזוכט אונזער וועבזייטל אדער רופט דעם  
טעלעפאן נומער וואס שטייט אויף דעם דאקומענט. (Yiddish)