

2019 SUMMARY OF BENEFITS



Overview of your plan

AARP® MedicareComplete® Value (HMO)

H5253-033

Look inside to learn more about the health services and drug coverages the plan provides. Call Customer Service or go online for more information about the plan.



Toll-free 1-844-723-6473, TTY 711
8 a.m. - 8 p.m. local time, 7 days a week



www.AARPMedicarePlans.com

AARP | MedicareComplete®
insured through UnitedHealthcare

Our service area includes these counties in:

Wisconsin: Milwaukee, Ozaukee, Racine, Washington, Waukesha.

Summary of Benefits

January 1st, 2019 - December 31st, 2019

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. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.AARPMedicarePlans.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

AARP® MedicareComplete® Value (HMO) is a Medicare Advantage HMO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed inside the cover, and be a United States citizen or lawfully present in the United States.

Use network providers and pharmacies.

AARP® MedicareComplete® Value (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers or pharmacies that are not in our network, the plan may not pay for those services or drugs, or you may pay more than you pay at an in-network pharmacy.

You can go to www.AARPMedicarePlans.com to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

AARP® MedicareComplete® Value (HMO)

Premiums and Benefits	In-Network
Monthly Plan Premium	There is no monthly premium for this plan.
Annual Medical Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Amount (does not include prescription drugs)	<p>\$5,900 annually for Medicare-covered services you receive from in-network providers.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your share of the cost for your Part D prescription drugs.</p>

AARP® MedicareComplete® Value (HMO)

Benefits		In-Network
Inpatient Hospital		\$410 copay per day: for days 1-4 \$0 copay per day: for days 5 and beyond
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital		\$395 copay Cost sharing for additional plan covered services will apply.
Outpatient Hospital Observation Services		\$395 copay
Doctor Visits	Primary	\$15 copay
	Specialists	\$50 copay
Preventive Care	Medicare-covered	\$0 copay
		Abdominal aortic aneurysm screening Alcohol misuse counseling Annual “Wellness” visit Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screening Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings and monitoring Hepatitis C screening HIV screening Lung cancer with low dose computed tomography (LDCT) screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screenings and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screenings and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)

Benefits		In-Network
		<p>Vaccines, including flu shots, hepatitis B shots, pneumococcal shots “Welcome to Medicare” preventive visit (one-time)</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.</p>
	Routine physical	\$0 copay; 1 per year
Emergency Care		<p>\$90 copay (worldwide) per visit If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>
Urgently Needed Services		\$30 - \$40 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays	Diagnostic radiology services (e.g. MRI)	\$100 copay per service
	Lab services	\$2 copay
	Diagnostic tests and procedures	20% coinsurance
	Therapeutic Radiology	\$50 copay per service
	Outpatient X-rays	\$14 copay per service
Hearing Services	Exam to diagnose and treat hearing and balance issues	\$15 copay
	Routine hearing exam	\$15 copay; 1 per year
	Hearing aid	\$300 - \$370 copay for each hearing aid provided through hi HealthInnovations®, or \$400 - \$2,025 copay for each hearing aid provided through EPIC Hearing Health Care. Up to 2 hearing aids every 2 years.

Benefits		In-Network
Routine Dental Services		Additional dental benefits available with a separate premium. Please see optional benefits section below for details.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye	\$0 copay
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$0 copay Up to 1 every year
Mental Health	Inpatient visit	\$410 copay per day: for days 1-3 \$0 copay per day: for days 4-90
		Our plan covers 90 days for an inpatient hospital stay.
	Outpatient group therapy visit	\$15 copay
	Outpatient individual therapy visit	\$20 copay
Skilled Nursing Facility (SNF)		\$0 copay per day: for days 1-20 \$160 copay per day: for days 21-57 \$0 copay per day: for days 58-100
		Our plan covers up to 100 days in a SNF.
Physical therapy and speech and language therapy visit		\$40 copay
Ambulance		\$225 copay for ground \$225 copay for air
Routine Transportation		\$0 copay; 24 one-way trips per year to or from approved locations
Medicare Part B Drugs	Chemotherapy drugs	20% coinsurance
	Other Part B drugs	20% coinsurance

Prescription Drugs

If you reside in a long-term care facility, you pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription Deductible	\$0 per year for Tier 1 and Tier 2; \$305 for Tier 3, Tier 4 and Tier 5 Part D prescription drugs.			
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	Retail		Mail Order	
	Standard		Preferred	Standard
	30-day supply	90-day supply	90-day supply	90-day supply
Tier 1: Preferred Generic Drugs	\$4 copay	\$12 copay	\$0 copay	\$12 copay
Tier 2: Generic Drugs	\$14 copay	\$42 copay	\$0 copay	\$42 copay
Tier 3: Preferred Brand Drugs	\$47 copay	\$141 copay	\$131 copay	\$141 copay
Tier 4: Non-Preferred Drugs	\$100 copay	\$300 copay	\$290 copay	\$300 copay
Tier 5: Specialty Tier Drugs	27% coinsurance	27% coinsurance	27% coinsurance	27% coinsurance
Stage 3: Coverage Gap Stage	After your total drug costs reach \$3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.			
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay the greater of: <ul style="list-style-type: none"> □ 5% coinsurance, or □ \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copay for all other drugs. 			

Additional Benefits		In-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation	\$20 copay
Diabetes Management	Diabetes monitoring supplies	\$0 copay We only cover ACCU-CHEK® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio®, OneTouch Verio® IQ, OneTouch Verio® Flex, ACCU-CHEK® Guide, ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®. Other brands are not covered by your plan.
	Diabetes Self-management training	\$0 copay
	Therapeutic shoes or inserts	20% coinsurance
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)	20% coinsurance
Fitness program through Renew Active™		Standard membership to participating fitness locations with access to group fitness classes – depending on availability. Programs such as: online brain exercises, activities and an in-person fitness orientation at no cost to you. For the complete details about the program, please visit www.myrenewactive.com , and click the link in the footer entitled Terms and Conditions.
Foot Care (podiatry services)	Foot exams and treatment	\$50 copay
	Routine foot care	\$50 copay; for each visit up to 6 visits every year
Meal Benefit		\$0 copay; Coverage for at home meal benefit. Restrictions apply.

Additional Benefits		In-Network
Home Health Care		\$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
NurseLine		Speak with a registered nurse (RN) 24 hours a day, 7 days a week
Occupational Therapy Visit		\$40 copay
Outpatient Substance Abuse	Outpatient group therapy visit	\$15 copay
	Outpatient individual therapy visit	\$20 copay
Outpatient Surgery		\$395 copay
UnitedHealth Passport®		Allows you to access all the benefits you enjoy at home while you travel within the covered service area for up to nine 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.
Renal Dialysis		20% coinsurance
Solutions for Caregivers		\$0 copay; Help from an experienced care manager who can support you in the care of a loved one, services available 24 hours a day, 7 days a week.

Optional Supplemental Benefits

Premiums and Benefits		In-Network
Dental Platinum Rider	Premium	Additional \$39.00 per month

Optional Supplemental Benefits

Premiums and Benefits		In-Network
	Description	The Dental Platinum Rider includes preventive and comprehensive dental benefits.

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies. A Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

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 <https://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.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY : 711)。

This information is available for free in other languages. Please call our customer service number located on the first page of this book.

Esta información esta disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la cobertura de este libro.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Every year, Medicare evaluates plans based on a 5-star rating system.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

If you have not used OptumRx home delivery, you must approve the first prescription order sent

directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-877-266-4832, TTY 711.

Participation in the Renew Active™ by UnitedHealthcare program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Equipment and classes may vary by location. Services, including equipment, classes, personalized fitness plans provided by fitness centers, and brain activities provided by BrainHQ, are provided by third parties not affiliated with AARP or UnitedHealthcare. AARP and UnitedHealthcare do not endorse and are not responsible for the services or information provided by this program. Availability of the Renew Active™ program varies by plan/area.

The Nurseline service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

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 the number listed on the back cover of this book.

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. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ 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 copays/coinsurance may change on January 1, 2019.
- ✓ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Vendor Information

As a member of the plan you get additional supplemental benefits not covered by Original Medicare. To get the most out of your additional benefits choose a network provider. You can find network providers online. You can also call Customer Service to help you find a network provider, or you can request to receive a paper copy.

Please see Chapter 4 of the Evidence of Coverage for details about these additional plan benefits.

Before contacting any of the providers below you must be fully enrolled in the plan.

Benefit Type	Vendor Name	Contact Information
Hearing Exams	Plan network providers in your service area	1-800-643-4845, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week www.myAARPMedicare.com
Hearing Aids	EPIC Hearing Health Care/hi HealthInnovations®	<p>EPIC Hearing Health Care 1-866-956-5400, TTY 711 6 a.m. - 6 p.m. PT, Monday - Friday www.epichearing.com</p> <p>hi HealthInnovations® 1-855-523-9355, TTY 711 9 a.m. - 5 p.m. CT, Monday - Friday www.hihealthinnovations.com</p> <p>You may choose to order hearing aids either through EPIC Hearing Health Care or through hi HealthInnovations®.</p>
Vision Care	Plan network providers in your service area	1-800-643-4845, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week www.myAARPMedicare.com
NurseLine	NurseLine	1-877-365-7949, TTY 711 24 hours a day, 7 days a week
Routine Transportation (Limited to ground transportation only)	LogistiCare®	1-866-418-9812, TTY 1-866-288-3133 8 a.m. - 5 p.m. local time, Monday - Friday www.logisticare.com

Benefit Type	Vendor Name	Contact Information
Meal Benefit	Mom's Meals NourishCare®	1-866-204-6111, TTY 711 7 a.m. – 6 p.m. CT, Monday – Friday http://www.momsmeals.com/care-transitions/
Fitness Membership	Renew Active™	1-800-643-4845, TTY 711 8 a.m. - 8 p.m. local time, 7 days a week www.myrenewactive.com
Supports for Caregivers	UnitedHealthcare	1-888-303-6163, TTY 711 24 hours a day, 7 days a week www.UHCforCaregivers.com

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare - H5253

2018 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2018, UnitedHealthcare received the following Overall Star Rating from Medicare.

★★★★★
4 stars

We received the following Summary Star Rating for UnitedHealthcare's health/drug plan services:

Health Plan Services: ★★★★★
4 stars

Drug Plan Services: ★★★★★
3.5 stars

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Local time, at 800-555-5757 (toll-free) or 711 (TTY).

Current members please call 800-643-4845 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY : 711).

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the member toll-free phone number listed in the front of this booklet.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed in the front of this booklet.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على رقم الهاتف المجاني للعضو الموجود في مقدمة هذا الكتيب.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان اعضا که بر روی جلد این کتابچه قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया इस पुस्तिका के सामने के पृष्ठ पर सूचीबद्ध सदस्य टोल-फ्री फ़ोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកឥតចេញថ្លៃ បានកត់នៅខាងមុខនៃកូនសៀវភៅនេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníl'ti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shóodí díí naaltsoos bidáahgi t'áá jíik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.