Summary of Benefits 2027

January 1, 2027 through December 31, 2027
This is a summary of your plan's costs and coverage. For a complete list of what we cover and any limitations, review the plan's *Evidence of Coverage* (EOC) at **AetnaMedicare.com/H4711-011** or call us to request a copy.

Your questions are important to us, and we're here to help

If you are an Aetna plan member, call:
1-866-409-1221 (**TTY: 711**)
8 AM to 8 PM, 7 days a week

If you are not yet an Aetna plan member, call:
1-844-509-6254 (**TTY: 711**)
October 1–March 31: 8 AM to 8 PM, 7 days a week
April 1–September 30: 8 AM to 8 PM, Monday–Friday

An Aetna team member will answer your call.

2027-H4711.011.1

About this plan

Aetna Medicare Partial Dual (HMO D-SNP) is a D-SNP, or Dual Eligible Special Needs plan. This is a Medicare Advantage plan that covers prescription drugs. Our D-SNP is for people on Medicare who are also eligible for some level of Medicaid assistance. It replaces your Original Medicare coverage. You'll still have Medicare, but you'll get it through us instead of the federal government. We cover everything that Original Medicare covers, and we provide additional benefits and services too. Please take a moment to review the following important information:

- **Primary care provider (PCP):** We require that you select a network PCP to help coordinate your care. When you enroll, we'll ask which PCP you have chosen. If you don't choose a PCP, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal. Be sure to show your Aetna® member ID card and, if you are supplied with one, your state Medicaid ID card when you visit a provider or pharmacy.
- **Referrals:** Aetna Medicare Partial Dual (HMO D-SNP) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your PCP in order to see you.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit **AetnaMedicare.com/H4711-011**. For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at **Medicare.gov/medicare-and-you**, or get a copy by calling 1-800-MEDICARE (**1-800-633-4227**) (**TTY: 1-877-486-2048**), 24 hours a day, 7 days a week.

Better health is a team effort

With our Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), you'll have a care team in your corner, ready to help you reach your best health and make life easier.

- Your **nurse care manager** is a single point of contact to help coordinate your care.
- Your **social worker** will link you to programs in your community and help with questions you have about social services.
- Your **care coordinator** will help schedule provider appointments, arrange rides, and work with you to meet your personal needs.
- We have teamed up with BeneLynk to assist you with your state Medicaid benefits and Extra Help for prescription drug assistance.

Are you eligible to enroll?

To join **Aetna Medicare Partial Dual (HMO D-SNP)**, you'll need to meet the following criteria:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Be in a "Medicare Savings Program" (MSP) or qualify for state Medicaid benefits. See the table below for eligibility categories.
- Live in the plan's service area, which includes the following counties:
  Nevada: Carson City, Churchill, Clark, Douglas, Lyon, Nye, Storey, Washoe

  New enrollment is closed to beneficiaries residing in Carson City, Churchill, Clark, Douglas, Lyon, Nye, Storey, and Washoe counties. If you're currently a member residing in any of these counties, you may continue your membership through plan year 2027. However, if you disenroll from the plan, you cannot re-enroll at a later date.

Medicare Savings Program

Eligibility category	What it covers
Qualified Medicare Beneficiary (QMB)	Helps pay Medicare Part A and Part B premiums, and other cost sharing like deductibles, coinsurance, and copayments. Some people with QMB are also eligible for full Medicaid benefits (QMB+).

Plan premium, deductible, and maximum out-of-pocket (MOOP)

Understanding out-of-pocket costs

- **Plan premium:** the amount you pay monthly to keep your health insurance active.
- **Deductible:** the amount you must pay for health care before our plan pays.
- **Maximum out-of-pocket:** the most you'll pay out of pocket in a plan year for covered care.

Out-of-pocket costs	
Monthly plan premium	$0
Plan deductible	$0
MOOP	$9,850 So long as Medicaid continues to pay your Medicare deductible, coinsurance, and copayments, you will not have a maximum out-of-pocket responsibility.

Medical and hospital benefits

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount.

Hospital coverage

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Inpatient	$0 copay The plan covers 90 days each benefit period and up to 60 lifetime reserve days. Lifetime reserve days can only be used once.
Outpatient hospital observation services	$0 copay
Outpatient hospital	$0 copay
Ambulatory surgical center	$0 copay

Primary care provider (PCP) and specialist services

Benefit	Your costs in our plan
PCP	$0 copay
Specialist	$0 copay

Preventive, emergency, and urgent care

Benefit	Your costs in our plan
Preventive care	$0 copay For a full list of preventive services available, see the EOC.
Emergency and urgent care (inside the U.S.)	$0 copay for emergency care $0 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$0 copay for emergency care $0 copay for urgent care $0 copay for ambulance Maximum coverage: $250,000. This is the most we will pay for the combined cost of emergency care, urgent care, and emergency ambulance services received outside of the U.S.

Diagnostic services, labs, and imaging

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Diagnostic tests and procedures	$0 copay
Lab services	$0 copay
Diagnostic radiology services, such as CT/ CAT scan and MRI	$0 copay
Outpatient x-rays	$0 copay

Hearing services

Benefit	Your costs in our plan
Diagnostic hearing exam	$0 copay
Routine hearing exam	$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.
Hearing aids	You get an annual benefit amount (allowance) of $1,500 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through an authorized NationsHearing® network provider.

Dental services

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Dental services (non-Medicare covered)	$0 copay for covered services You get an annual benefit amount (allowance) of $3,000 for covered services. You are responsible for any costs over this amount. Covered services include oral exams, cleanings, fillings, extractions, crowns, dentures, and more. We have teamed up with Liberty Dental to provide your dental coverage. This benefit uses the Liberty Dental network, which is different from your medical network, for covered services. If you choose a provider outside of the Liberty Dental network, services will not be covered. See EOC for details on exclusions and limitations.

Vision services

Benefit	Your costs in our plan
Diagnostic eye exam (includes diabetic eye exams)	$0 copay
Glaucoma screening	$0 copay
Routine eye exam (one exam every year)	$0 copay with an EyeMed network provider
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $200 for covered prescription eyewear. Your benefit amount can only be used to purchase eyewear through an EyeMed network provider. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference.

Mental health services

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Inpatient psychiatric hospital stay	$0 copay There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.
Outpatient mental health therapy	$0 copay for individual sessions $0 copay for group sessions
Outpatient psychiatric therapy	$0 copay for individual sessions $0 copay for group sessions

Skilled nursing facility (SNF) and therapy

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

Benefit	Your costs in our plan
SNF care	$0 copay Our plan covers up to 100 days per benefit period.
Physical and speech therapy	$0 copay
Occupational therapy	$0 copay

Ambulance and routine transportation

Your provider needs approval from us before we cover non-emergency transportation. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Ambulance (ground or air, one-way trip)	$0 copay
Routine, non-emergency transportation	$0 copay You get up to 36 one-way trips every year to and from plan-approved locations (up to 100 miles each trip). Examples of plan-approved locations include medical offices and urgent care centers. We have teamed up with our authorized vendor SafeRide to provide this benefit.

Medicare Part B drugs

Medicare Part B only covers a limited number of medicines under certain conditions. These medicines are often given to you in your provider's office. They can include things like preventive vaccines, injections, and nebulizers, among others. They can also include medicines you take at home using special medical equipment. Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Chemotherapy drugs	$0 copay
Part B Insulin	$0 copay
Other Part B drugs	$0 copay

Medicare Part D drugs

Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes. Some drugs require prior authorization. This means you must get approval from us first before we'll cover them.

Prescription drug costs

Formulary Name: B2 (You can use this when referencing our list of covered drugs.)

If you qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:	
Deductible	$0
Initial coverage phase	Low Income Subsidy (LIS) cost sharing during the initial coverage phase (copayments or coinsurance may vary depending on your level of "Extra Help"): Covered generic drugs (including brand drugs treated as generic): $0, $1.65, or $5.80. For all other covered drugs: $0, $5.00, or $14.40.

If you do not qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:	
Deductible phase	You'll pay the plan's negotiated drug cost up to the deductible limit of $700. The deductible applies to drugs on Tiers 3, 4, and 5.
Initial coverage phase	The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled. You will pay the lesser of the listed copay/coinsurance below or the negotiated cost of the drug. These cost shares may also apply to home infusion drugs when obtained through your Part D benefit. Costs may differ based on pharmacy type or status.

One-month Supply
Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Standard Retail	Standard Mail	Long-Term Care (LTC)
	30-day	30-day	31-day
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generic	$0	$0	$0
Tier 3: Preferred Brand	9%	9%	9%
Tier 4: Non-Preferred Drug	25%	25%	25%
Tier 5: Specialty	25%	25%	25%

Long-term Supply
Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard Retail	Standard Mail
	100-day	100-day
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	9%	9%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty	A long-term supply is not available for drugs on Tier 5.	

You can get a 30, 60, or 100-day supply of most of your drugs through network retail and mail-order pharmacies. This includes home infusion drugs obtained through your Part D benefit. Note: Specialty drugs have a 30-day limit.

Out-of-pocket threshold	$2,400 is the maximum amount you will pay for your yearly Part D out-of-pocket costs.
Catastrophic coverage phase	In this phase, the plan pays the full cost for your covered Part D drugs. You'll pay $0 for generic and brand name drugs in this phase.
Insulins and vaccines	Part D insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in, even if you haven't paid your deductible. Part D preventive vaccines: Our plan covers many vaccines at no cost to you, even if you haven't paid your deductible. Check your formulary guide for a list of covered Part D insulins and vaccines.

Other covered benefits

Aetna® Medicare Extra Benefits Card

You get an Aetna Medicare Extra Benefits Card to help pay for certain everyday expenses. Qualifying members may be eligible for additional spending categories. See the Special Supplemental Benefits chart for more details.

Benefit	
Over-the-Counter (OTC) Wallet	You get a $117 monthly benefit amount (allowance) on the Aetna® Medicare Extra Benefits Card. You can use your Over-the-Counter (OTC) Wallet to help pay for certain OTC health and wellness products including allergy medicine, pain relievers, first aid supplies, and more. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at **CVS.com/Aetna**, or shop by phone. Important: • If you received an Aetna Medicare Extra Benefits Card in 2026 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2027 plan year. • If you are a new member or were not enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026, you should get a new card before your plan begins. • If you enrolled in a plan with an Aetna Medicare Extra Benefits Card in 2026 and changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.

Alternative medicine

Benefit	Your costs in our plan
Acupuncture	$0 copay for Medicare-covered acupuncture visits Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.
Chiropractic services	$0 copay for Medicare-covered chiropractic visits Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.

Diabetic supplies

Benefit	Your costs in our plan
Diabetic supplies	$0 copay for Medicare-covered diabetic supplies We exclusively cover Accu-Chek/Roche and TRUE/ Trividia blood glucose meters (BGMs) and test strips as preferred supplies. $0 copay for Medicare-covered continuous glucose monitors (CGMs)

Fitness benefit

Benefit	Your costs in our plan
Basic SilverSneakers® fitness membership	$0 copay You get a basic membership to any authorized participating SilverSneakers® fitness facility. Additionally, online classes and at-home fitness kits are available. You may order one fitness kit per year through SilverSneakers.

Foot care (podiatry services)

Benefit	Your costs in our plan
Foot exams and treatment	$0 copay for Medicare-covered and non-Medicare covered podiatry visits For non-Medicare covered services, we cover up to twelve visits every year.

Home care and support

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Home health care, such as part-time skilled nursing and health aide services, and physical therapy	$0 copay for Medicare-covered home health care services Non-Medicare covered home health care services are not covered.
Meal benefit (post-discharge)	$0 copay for the meal benefit when you use our authorized vendor, NationsMarket™ After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 14 freshly prepared meals for a 7-day period. These meals are provided to help support your recovery or manage your health conditions. We have teamed up with our authorized vendor NationsMarket™ to provide this benefit.
Personal emergency response system	$0 copay Our plan covers a medical alert response system through our authorized vendor LifeStation to provide you with 24/7 access to help in the event of a fall or an emergency. LifeStation is our authorized vendor for this benefit. Members access this benefit through Aetna care management.

Medical equipment and supplies

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Durable medical equipment (DME), such as wheelchairs, crutches, and oxygen equipment	$0 copay
Prosthetics, such as braces and artificial limbs	$0 copay
Fall prevention	You will receive a $150 annual benefit amount (allowance) to purchase certain approved home and bathroom safety products.

Resources For Living®

Benefit	Your costs in our plan
Resources For Living®	Resources For Living® helps connect you with local community services such as caregiver support, meal and in-home care services, volunteer activities, and transportation. These services are not the same as the benefits covered by your Aetna plan, and Aetna does not provide the services. If you use services that have costs, you'll need to pay for those. Resources For Living® also offers one-on-one coaching at no added cost to support your personal goals, such as improving physical wellness, building social connections, or focusing on personal growth.

Substance use disorder services

Your provider may need approval from us before we cover these services. This is called prior authorization or precertification.

Benefit	Your costs in our plan
Outpatient substance use disorder services	$0 copay for individual sessions $0 copay for group sessions

24-Hour Nurse Line

You can talk to a registered nurse anytime to discuss health-related questions. While only your doctor can diagnose, prescribe, or give medical advice, the 24-Hour Nurse Line can provide information on a variety of health topics.

Benefit	Your costs in our plan
24-Hour Nurse Line	$0

Special supplemental benefits

Our plan offers additional benefits to qualifying members. See the EOC for a full list of eligibility criteria.

Extra Supports Wallet	
Eligibility requirements	If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet all other criteria, you may be eligible for additional benefits under our plan to help manage your overall health and wellness. Enrollment in the plan does not guarantee eligibility. You will receive special supplemental benefits after it is determined that you meet the eligibility requirements. However, you will not receive benefits for any time period before your eligibility was determined.

Extra Supports Wallet	
Benefits	After meeting all eligibility requirements, the $117 monthly benefit amount in the Over-the-Counter (OTC) Wallet will change to the Extra Supports Wallet with additional spending categories. Qualified members can use this wallet to help pay for certain healthy foods, over-the-counter (OTC) health and wellness products, transportation, utilities, and personal care products. This will replace your OTC Wallet. You will not get any additional funds applied to your card. Approved products can be purchased in-store at authorized participating locations including CVS® retail locations (excluding locations inside other stores). You can also use the CVS Flex Benefits™ app, go online at **CVS.com/Aetna**, or shop by phone. Important: If you qualify, this wallet will be added to your current Aetna® Medicare Extra Benefits Card.

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include but are not limited to: hypertension, hyperlipidemia, diabetes, cardiovascular disorders, and chronic lung disorders. Eligibility is determined by whether you have a chronic condition associated with the benefit(s) and you meet all other criteria. Even if you have a listed chronic condition, you may not necessarily receive the benefit because other eligibility and coverage criteria may apply. Standards and conditions vary for each benefit. Contact us to confirm the specific SSBCI condition requirements for the benefit(s) for this plan and determine your eligibility.

Disclaimers

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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.

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

Aetna is part of the CVS Health® family of companies.

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

For mail order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call **1-866-409-1221** (**TTY:** **711**) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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Resources For Living® is the brand name used for products and services offered through the Aetna group of subsidiary companies.

SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved.

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (**1-800-633-4227**) (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

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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 1-844-509-6254 (**TTY:** 711). From October 1 to March 31, you can call us 7 days a week from 8 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

Understanding the benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit AetnaMedicare.com or call 1-844-509-6254 (**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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding important rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part B premium is covered for full-dual members.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ 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).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

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Notice of Availability (NOA)

TTY: 711

To access language services at no cost to you, call the number on this document. (English)

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للحصول على خدمات اللغة مجانًا، اتصل بالرقم المذكور في هذه الوثيقة. (Arabic)

如欲使用免費語言服務，請致電本文件上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa doookumentii kanarra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro indiqué sur ce document. (French)

Pou jwenn sèvis lang san ou pa peye anyen, rele nimewo ki sou dokiman sa a. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer in diesem Dokument an. (German)

Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kēia palapala. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj ntawm daim ntawv no. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato in questo documento. (Italian)

無料の言語サービスをご利用いただくには、この書類に記載されている番号にお電話ください。 (Japanese)

လၢကမၤန့ၣ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိာ်လာ်ဘူာ်လာ်စ့ၤ လၢနဂိၢ်အဂိၢ်, ကိးနီာ်ဂံၢ် လၢအအိာ်ဖဲလံာ်တိလံာ်မိအံၤ အဖိခိာ်နၣ်တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 이 문서에 있는 전화번호로 전화하세요. (Korean)

ເພ່ ອ ້ ໍ ໃຊ ້ ການ ບ ໍ ລ ິ ການ ພ າ ສ າ ໂ ດ ຍ ບ ເ ສ ຍ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ ໃ ດ ໆ, ໃ ຫ ້ ໂ ທ ຫ າ ເ ບ ໍ ໂ ທ ໃ ນ ເ ອ ກ ະ ສ າ ນ ້ ໍ. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរស័ព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

برای دسترسی به خدمات زبانی رایگان، با شماره مندرج در این سند تماس بگیرید. (Persian farsi)

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany w tym dokumencie. (Polish)

Ligue para o número indicado neste documento para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному в этом документе. (Russian)

Para acceder a servicios de idiomas sin costo alguno, llame al número que aparece en este documento. (Spanish)

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa dokumentong ito. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại ghi trên tài liệu này.
(Vietnamese)

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