

Aetna Medicare Chronic Care Value (HMO C-SNP)  
H3146 - 044 | \$36.20 Plan Premium



## 2026 Summary of Benefits

### We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

### Not a member yet?

Call [1-833-771-2456](tel:1-833-771-2456) (TTY: [711](tel: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

### Already a member?

Call [1-833-595-1008](tel:1-833-595-1008) (TTY: [711](tel:711))

8 AM to 8 PM, 7 days a week  
An Aetna team member will answer your call.

### Keep in mind

This is a summary of the services we cover from January 1, 2026 through December 31, 2026.

Need a complete list of what we cover and any limitations? Just visit [AetnaMedicare.com/H3146-044](https://www.aetna.com/H3146-044) where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

## Are you eligible to enroll?

**To join Aetna Medicare Chronic Care Value (HMO C-SNP), you must:**

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:  
**North Carolina:** Cabarrus, Gaston, Mecklenburg, Union
- Must have one of the following qualifying conditions verified by a physician: diabetes mellitus, chronic heart failure, and/or cardiovascular disorders.

## What you should know

- **Plan type:** Aetna Medicare Chronic Care Value (HMO C-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. This is a Medicare Advantage plan that covers prescription drugs.
- **Primary Care Provider (PCP):** A PCP is important to help coordinate your care. We require you to select a PCP. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal.
- **Referrals:** Aetna Medicare Chronic Care Value (HMO C-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 provider 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/H3146-044](https://AetnaMedicare.com/H3146-044). For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you), or get a copy by calling 1-800-MEDICARE ([1-800-633-4227](tel:1-800-633-4227)) (TTY: [1-877-486-2048](tel:1-877-486-2048)), 24 hours a day, 7 days a week.

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



| Out-of-pocket costs  |                                                                                                                                                                             |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly plan premium | \$36.20<br>You must continue to pay your Medicare Part B premium.                                                                                                           |
| Plan deductible      | \$0                                                                                                                                                                         |
| MOOP                 | \$9,250<br>Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP. |

## Medical and hospital benefits



### 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                                | \$399 per day, days 1-6; \$0 per day, days 7-90<br>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 | \$399 copay                                                                                                                                                                     |
| Outpatient hospital                      | \$30 - \$399 copay<br>\$30 copay for outpatient hospital services other than surgery<br>\$399 copay for each outpatient hospital surgery                                        |
| Ambulatory surgical center               | \$349 copay                                                                                                                                                                     |



### Primary Care Provider (PCP) and specialist visits

| Benefit    | Your costs in our plan                                                                                                                                                                                          |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PCP        | \$0 copay                                                                                                                                                                                                       |
| Specialist | \$0 - \$30 copay<br><br>\$0 copay for certain physician specialist visits including: Cardiologists, Endocrinologists, Nephrologists, and Pulmonologists<br>\$30 copay for all other physician specialist visits |



### Preventive, emergency and urgent care

| Benefit                                                                     | Your costs in our plan                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Preventive care                                                             | \$0 copay<br><br>For a full list of preventive services available, see the EOC. Some covered services may have an associated cost.                                                                                                      |
| Emergency and urgent care (inside the U.S.)                                 | \$115 copay for emergency care<br>\$40 copay for urgent care                                                                                                                                                                            |
| Emergency and urgent care, including emergency ambulance (outside the U.S.) | \$115 copay for emergency care<br>\$115 copay for urgent care<br>\$275 copay for ambulance<br><br>Maximum coverage: \$250,000 (the most we'll pay for your worldwide emergency and urgent care combined, including emergency ambulance) |



### Diagnostic services, labs, 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 - \$200 copay<br><br>\$0 copay for services provided by your primary care provider in their office<br>\$200 copay for services performed by a provider other than your primary care provider<br>\$0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing |
| Lab services                                               | \$0 copay                                                                                                                                                                                                                                                                                                                                                    |
| Diagnostic radiology services, such as CT/CAT scan and MRI | \$0 - \$300 copay<br><br>\$0 copay for services provided by your primary care provider in their office<br>\$300 copay for services performed by a provider other than your primary care provider                                                                                                                                                             |
| Outpatient x-rays                                          | \$0 - \$14 copay<br><br>\$0 copay for services provided by your primary care provider in their office<br>\$14 copay for services performed by a provider other than your primary care provider                                                                                                                                                               |



### Hearing services

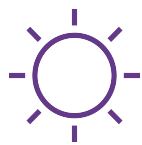
| Benefit                 | Your costs in our plan                                                                                                                                                                                                                  |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic hearing exam | \$30 copay                                                                                                                                                                                                                              |
| Routine hearing exam    | \$0 copay<br><br>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 \$750 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 a NationsHearing network provider. |

**Dental services**

| Benefit                                | Your costs in our plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dental services (non-Medicare covered) | <p>\$0 copay for covered services</p> <p>You get an annual benefit amount (allowance) of \$1,000 for covered services. You are responsible for any costs over this amount.</p> <p>Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more.</p> <p>This benefit uses the Aetna Dental PPO Network, which is different from your medical network, for covered services. If you choose a provider outside of the Aetna Dental PPO Network, services will not be covered. See EOC for details on exclusions and limitations.</p> |

**Vision services**

| Benefit                                           | Your costs in our plan                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic eye exam (includes diabetic eye exams) | <p>\$0 - \$30 copay</p> <p>\$0 copay for diabetic eye exams</p> <p>\$30 copay for all other Medicare-covered eye exams</p>                                                                                                                                                                                              |
| Glaucoma screening                                | \$0 copay                                                                                                                                                                                                                                                                                                               |
| Routine eye exam (one exam every year)            | \$0 copay with an EyeMed provider                                                                                                                                                                                                                                                                                       |
| Contacts and eyeglasses                           | <p>You get an annual benefit amount (allowance) of \$100 for covered prescription eyewear.</p> <p>You can only use this benefit amount at an EyeMed 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.</p> |



### 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 | \$260 per day, days 1-8; \$0 per day, days 9-90<br>Our plan covers up to 190 days per benefit period. |
| Outpatient mental health therapy    | \$25 copay for individual sessions<br>\$25 copay for group sessions                                   |
| Outpatient psychiatric therapy      | \$25 copay for individual sessions<br>\$25 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 per day, days 1-20; \$218 per day, days 21-100<br>Our plan covers up to 100 days per benefit period. |
| Physical and speech therapy | \$35 copay                                                                                               |
| Occupational therapy        | \$35 copay                                                                                               |



### Ambulance and routine transportation

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

| Benefit                                    | Your costs in our plan                                                                  |
|--------------------------------------------|-----------------------------------------------------------------------------------------|
| Ambulance<br>(ground or air, one-way trip) | \$275 copay for ground ambulance services<br>20% coinsurance for air ambulance services |
| Routine, non-emergency transportation      | Not Covered                                                                             |

**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 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% - 20% coinsurance<br><br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. |
| Part B Insulin     | \$35 copay                                                                                                                                    |
| Other Part B drugs | 0% - 20% coinsurance<br><br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. |

## 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 (your costs may be lower if you qualify for "Extra Help")

Formulary name: B2\_CSNP (you can use this when referencing our list of covered drugs).

### Deductible phase

You'll pay the plan's negotiated drug cost up to the deductible limit of \$615. 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<br>Retail | Standard<br>Mail | Long-Term Care<br>(LTC) |
|----------------------------|--------------------|------------------|-------------------------|
|                            | 30-day             | 30-day           | 31-day                  |
| Tier 1: Preferred Generic  | \$0                | \$0              | \$0                     |
| Tier 2: Generic            | \$5                | \$5              | \$5                     |
| Tier 3: Preferred Brand    | 25%                | 25%              | 25%                     |
| 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<br>Retail                                       | Standard<br>Mail |
|----------------------------|----------------------------------------------------------|------------------|
|                            | 100-day                                                  | 100-day          |
| Tier 1: Preferred Generic  | \$0                                                      | \$0              |
| Tier 2: Generic            | \$15                                                     | \$10             |
| Tier 3: Preferred Brand    | 25%                                                      | 25%              |
| Tier 4: Non-Preferred Drug | 25%                                                      | 25%              |
| Tier 5: Specialty          | A long-term supply is not available for drugs on Tier 5. |                  |

### Out-of-pocket threshold

\$2,100 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**

Important message about what you pay for 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.

Important message about what you pay for Part D 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 insulins and vaccines.

## Other covered benefits



### Alternative medicine

| Benefit               | Your costs in our plan                                                                                                                                                                    |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acupuncture           | \$30 copay for Medicare-covered acupuncture visits<br>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered. |
| Chiropractic services | \$15 copay for Medicare-covered chiropractic visits<br>Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.                  |



### Diabetic supplies

We exclusively cover **Accu-Chek/Roche and TRUE/Trividia** blood glucose meters and test strips as our preferred diabetic supplies.

| Benefit           | Your costs in our plan |
|-------------------|------------------------|
| Diabetic supplies | \$0 copay              |



### Fitness benefit

| Benefit                            | Your costs in our plan                                                                                                                                                                                                                                                                                                              |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Annual physical fitness membership | \$0 copay<br><br>You get a basic membership to any SilverSneakers® participating fitness facility. If you prefer to exercise at home, you may order one at-home fitness kit per year through SilverSneakers. If you do not reside near a participating facility, online fitness classes are available at no additional cost to you. |



### Foot care (podiatry services)

| Benefit                  | Your costs in our plan                                                                                                                                                           |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Foot exams and treatment | \$0 copay for Medicare-covered podiatry visits<br>\$0 copay for non-Medicare covered podiatry visits<br>For non-Medicare covered services, we cover up to six 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 | \$0 copay              |



### 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, oxygen equipment, and continuous glucose monitors (CGMs) | 0% - 20% coinsurance<br>0% coinsurance for continuous glucose monitors<br>20% coinsurance for all other Medicare-covered DME items |
| Prosthetics, such as braces and artificial limbs                                                                         | 20% coinsurance                                                                                                                    |



### Resources For Living®

| Benefit              | Your costs in our plan                                                                                                                                       |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Resources For Living | Resources For Living helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more. |



### 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 | \$25 copay for individual sessions<br>\$25 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 copay              |

**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:**

Members must be diagnosed with one or more of the chronic conditions listed in the EOC and meet the eligibility criteria to be eligible for this plan. Members who qualify for enrollment in this plan may be eligible to receive the additional benefits listed below.

**Benefits:**

By qualifying for enrollment in this plan, you get an **Extra Supports Wallet** with a \$50 monthly benefit amount (allowance) on an **Aetna Medicare Extra Benefits Card**.

You can use your Extra Supports Wallet to help pay for certain healthy foods, over-the-counter (OTC) health and wellness products, transportation, utilities, and personal care products. Approved products can be purchased in-store at participating locations including CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®.

**Important:**

- If you received an Extra Benefits Card in 2025 and have not changed plans, keep your card. You will not receive a new card in the mail for the 2026 plan year.
- If you are a new member or were not enrolled in a plan with an Extra Benefits Card in 2025, you should get a new card before your plan begins.
- If you changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.

**Aetna High Value Provider Incentive Program (HVPIP)****Eligibility requirements:**

A High Value primary care provider (PCP) can offer a holistic approach to managing your care. You may be eligible for the additional supplemental benefit(s) shown below if you select a qualifying High Value PCP. For more information on the program and how to qualify, see the EOC.

**Benefits:**

If you qualify, you get:

- **Extra Supports Wallet bonus:**
  - \$30 monthly additional benefit amount (allowance) added to your Extra Supports Wallet

The benefit(s) mentioned are part of special supplemental benefits for the chronically ill (SSBCI). SSBCI conditions include certain cardiovascular disorders, congestive heart failure, and diabetes. Eligibility is determined by whether you have a chronic condition associated with the benefit(s). 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.

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.

The Aetna C-SNP is available to Medicare members who have at least one of the qualifying chronic conditions. To ensure a successful enrollment process, we'll confirm with your healthcare provider that you have one of these eligible conditions. If verification of eligible condition is not received, involuntary disenrollment will occur.

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 [1-833-595-1008](tel:1-833-595-1008) (TTY: [711](tel:1-833-595-1008)) 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.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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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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](tel:1-800-633-4227)) (TTY users should call [1-877-486-2048](tel: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 [1-833-771-2456](tel:1-833-771-2456) (TTY: [711](tel:1-833-771-2456)). 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](https://www.aetna.com) or call [1-833-771-2456](tel:1-833-771-2456) (TTY: [711](tel:1-833-771-2456)) 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.
- ☐ 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, 2027.
- ☐ 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 chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

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## Notice of Availability (NOA)

### TTY: [711](tel: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 'oe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona 'oe 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)

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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)

လၢကမၤန့ၢ် ကျိၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢၣ်ဘျၣ်လၢၣ်စ့ၤ လၢန့ၢ်ဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီၢ်လံာ်မိအံၤ အဖီခိၣ်န့ၣ်တက့ၢ်. (Karen)

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