Aetna Medicare Elite (PPO)
H5521 - 536 | $0 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 1-833-859-6031 (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

Already a member?
Call 1-833-570-6670 (TTY: 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/H5521-536** where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

2026-H5521.536.1

Are you eligible to enroll?

To join Aetna Medicare Elite (PPO), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following county:
  New York: Richmond

What you should know

- **Plan type:** Aetna Medicare Elite (PPO) is a PPO plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care.
- **Primary Care Provider (PCP):** You have the option to choose a PCP. We recommend choosing a PCP because when we know who your provider is we can better support your care.
- **Referrals:** Aetna Medicare Elite (PPO) 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/H5521-536**. 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.

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

Out-of-pocket costs	
Monthly plan premium	$0 You must continue to pay your Medicare Part B premium.
Plan deductible	$1,000 for certain in-network and out-of-network services. Your deductible is what you'll pay before we begin to pay for services. The plan deductible applies to the following services provided by an in-network provider: inpatient hospital coverage, inpatient services in a psychiatric hospital, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgical center and dialysis. Additionally, the plan deductible applies to certain out-of-network services.
MOOP	$9,250 for in-network services $13,900 for in- and out-of-network services combined 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 in-network costs	Your out-of-network costs
Inpatient (unlimited number of days)	$407 per day, days 1-6; $0 per day, days 7-90; $0 for additional days after your plan deductible is met	$500 per day, days 1-20; $0 per day, days 21-90 after your plan deductible is met; $0 for additional days
Outpatient hospital observation services	$407 copay after your plan deductible is met	40% coinsurance after your plan deductible is met
Outpatient hospital	$45 - $407 copay after your plan deductible is met $45 copay for outpatient hospital services other than surgery $407 copay for each outpatient hospital surgery	40% coinsurance after your plan deductible is met
Ambulatory surgical center	$350 copay after your plan deductible is met	40% coinsurance after your plan deductible is met

Primary Care Provider (PCP) and specialist visits

Benefit	Your in-network costs	Your out-of-network costs
PCP	$5 copay	$50 copay after your plan deductible is met
Specialist	$45 copay	$60 copay after your plan deductible is met

Preventive, emergency and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	$0 copay	0% - 40% coinsurance 0% coinsurance for the pneumonia, flu/influenza, hepatitis B, and COVID-19 vaccines 40% coinsurance for all other Medicare-covered preventive services
	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 $40 copay for urgent care	$115 copay for emergency care $40 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	$115 copay for emergency care $115 copay for urgent care $275 copay for ambulance	$115 copay for emergency care $115 copay for urgent care $275 copay for ambulance
	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 in-network costs	Your out-of-network costs
Diagnostic tests and procedures	$45 copay $0 copay for certain Medicare-covered diagnostic tests and services including retinal fundus, spirometry, and peripheral arterial disease (PAD) testing	40% coinsurance after your plan deductible is met
Lab services	$5 copay $0 copay for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing	40% coinsurance after your plan deductible is met
Diagnostic radiology services, such as CT/CAT scan and MRI	$200 - $300 copay $200 copay for CT/CAT scans $300 copay for all other complex imaging	40% coinsurance after your plan deductible is met
Outpatient x-rays	$45 copay	40% coinsurance after your plan deductible is met

Hearing services

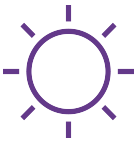
Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	$45 copay	$60 copay after your plan deductible is met
Routine hearing exam	$0 copay You get one routine hearing exam every year. You can visit a provider in the NationsHearing® network or an out-of-network provider.	$60 copay after your plan deductible is met
Hearing aids	Hearing aids are only covered when purchased through a NationsHearing provider. The copay amount is based on the level of hearing aid selected and will need to be paid at the time of purchase. • Level 1 (Standard): $0 copay per ear, per year • Level 2 (Select): $475 copay per ear, per year • Level 3 (Superior Plus): $650 copay per ear, per year • Level 4 (Advanced): $895 copay per ear, per year • Level 5 (Advanced Plus): $1,300 copay per ear, per year • Level 6 (Specialty): $1,700 copay per ear, per year	Not Covered

Dental services

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	$0 copay for preventive services	50% coinsurance for preventive services
	Covered preventive services include oral exams, cleanings, and x-rays. This plan does not include comprehensive services for things like fillings, extractions, crowns, and more. You can purchase comprehensive dental coverage through an Optional Supplemental Benefit (OSB) for an additional premium when you enroll or within 30 days of the plan's start date. You can use a provider in or out of the Aetna Dental PPO Network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may be required to pay in full for services and submit a request for reimbursement.	

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	$0 - $45 copay $0 copay for diabetic eye exams $45 copay for all other Medicare-covered eye exams	$60 copay after your plan deductible is met
Glaucoma screening	$0 copay	40% coinsurance after your plan deductible is met
Routine eye exam (one exam every year)	$0 copay with an EyeMed provider	$0 copay up to $50. You will be responsible for any billed amount over $50.
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $150 for covered prescription eyewear. We have teamed up with EyeMed to provide this benefit. You can choose to use a provider outside of the EyeMed network, but you may be responsible for additional costs. 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 in-network costs	Your out-of-network costs
Inpatient psychiatric hospital stay	$346 per day, days 1-6; $0 per day, days 7-90 after your plan deductible is met Our plan covers up to 190 days per benefit period.	40% per stay after your plan deductible is met
Outpatient mental health therapy	$45 copay for individual sessions $45 copay for group sessions	40% coinsurance for individual sessions after your plan deductible is met 40% coinsurance for group sessions after your plan deductible is met
Outpatient psychiatric therapy	$45 copay for individual sessions $45 copay for group sessions	40% coinsurance for individual sessions after your plan deductible is met 40% coinsurance for group sessions after your plan deductible is met

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 in-network costs	Your out-of-network costs
SNF care	$0 per day, days 1-20; $218 per day, days 21-100 after your plan deductible is met Our plan covers up to 100 days per benefit period.	40% per stay after your plan deductible is met
Physical and speech therapy	$35 copay	40% coinsurance after your plan deductible is met
Occupational therapy	$35 copay	40% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	$275 copay	$275 copay after your plan deductible is met
Routine, non-emergency transportation	Not Covered	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 in-network costs	Your out-of-network costs
Chemotherapy drugs	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	40% coinsurance after your plan deductible is met
Part B Insulin	$35 copay	$35 copay after your plan deductible is met
Other Part B drugs	0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	40% coinsurance after your plan deductible is met

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 (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:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail	Long-Term Care (LTC)
	30-day	30-day	30-day	30-day	31-day
Tier 1: Preferred Generic	$0	$2	$0	$2	$2
Tier 2: Generic	$0	$12	$0	$12	$12
Tier 3: Preferred Brand	24%	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	25%	25%	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:

	Preferred Retail	Standard Retail	Preferred Mail	Standard Mail
	100-day	100-day	100-day	100-day
Tier 1: Preferred Generic	$0	$6	$0	$6
Tier 2: Generic	$0	$36	$0	$36
Tier 3: Preferred Brand	24%	24%	24%	24%
Tier 4: Non-Preferred Drug	25%	25%	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 in-network costs	Your out-of-network costs
Acupuncture	$45 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.	$60 copay for Medicare-covered acupuncture visits after your plan deductible is met
Chiropractic services	$15 copay for Medicare-covered chiropractic visits Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.	40% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met

Diabetic supplies

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

Benefit	Your in-network costs	Your out-of-network costs
Diabetic supplies	0% - 20% coinsurance 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization	0% - 20% coinsurance after your plan deductible is met 0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies 20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization

Fitness benefit

Benefit	Your costs in our plan
Annual physical fitness membership	$0 copay 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 in-network costs	Your out-of-network costs
Foot exams and treatment	$45 copay for Medicare-covered podiatry visits	$60 copay for Medicare-covered podiatry visits after your plan deductible is met

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 in-network costs	Your out-of-network costs
Home health care	$0 copay	40% coinsurance after your plan deductible is met
Meal benefit (post-discharge)	$0 copay for meals 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 NationsMarket™ to provide this benefit.	

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 in-network costs	Your out-of-network costs
Durable medical equipment (DME), such as wheelchairs, crutches, oxygen equipment, and continuous glucose monitors (CGMs)	0% - 20% coinsurance 0% coinsurance for continuous glucose monitors 20% coinsurance for all other Medicare-covered DME items	40% coinsurance after your plan deductible is met
Prosthetics, such as braces and artificial limbs	20% coinsurance	40% coinsurance after your plan deductible is met

Resources For Living®

Benefit	
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 in-network costs	Your out-of-network costs
Outpatient substance use disorder services	$45 copy for individual sessions $45 copy for group sessions	40% coinsurance for individual sessions after your plan deductible is met 30% coinsurance for group sessions after your plan deductible is met

Visitor/travel benefit

Plan rules continue to apply. **Prior authorizations** are required for certain services.

Benefit	
Visitor/travel program: Explorer	Allows you to remain in your plan for up to 12 months when you are outside our plan's service area. While traveling within the United States, you can see an Aetna Medicare participating provider and pay in-network cost shares. Not all providers participate in the multi-state network. In most cases, when you receive non-urgent/non-emergency care from an out-of-network provider, your share of the costs for your covered services may be higher. Contact us for help finding a participating provider in the area you're traveling to.

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

Optional Supplemental Benefits

This plan offers **Optional Supplemental Benefits (OSB)**. If you want these benefits, you must sign up for them when you enroll or within 30 days of the plan's start date and pay an additional monthly premium.

Benefit	Your in-network costs	Your out-of-network costs
Deluxe Comprehensive Dental Package **Monthly premium:** $38		
Dental services (non-Medicare covered)	20% - 50% coinsurance for comprehensive services	50% - 70% coinsurance for comprehensive services
	When you enroll in this OSB, you get an annual benefit amount (allowance) of $1,500 for covered comprehensive services. You are responsible for the cost of any comprehensive services over this amount. Covered services include fillings, extractions, crowns, and more. You can use a provider in or out of the Aetna Dental PPO Network, which is different from your medical network, for covered services. However, if you use a provider outside of the network, you may be required to pay in full for services and submit a request for reimbursement. See EOC for details on exclusions and limitations.	

Special Supplemental Benefits

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

Aetna Cancer Care Support Program

Eligibility requirements:
If you've been diagnosed with cancer by a medical professional and are receiving active cancer treatment, you may be eligible for the Aetna Cancer Care Support Program.

Benefits:

If you qualify, you can get certain in-person and/or telehealth primary care provider (PCP) services with an Aetna-designated provider for $0.

Aetna Chronic Care Support Program

Eligibility requirements:
If you have been diagnosed by a medical professional with generally more than one medically complex chronic condition listed in the EOC, and you meet certain criteria, you may be eligible for the Aetna Chronic Care Support Program.

Benefits:

If you qualify, you can get certain primary care provider (PCP) services with an Aetna-designated provider for $0.

Aetna Kidney Care Support Program

Eligibility requirements:
If you have been diagnosed by a medical professional with one of the chronic conditions listed in the EOC and you meet certain criteria, you may be eligible for the Aetna Kidney Care Support Program.

Benefits:

If you qualify, you can get certain primary care provider (PCP) services for kidney care with an Aetna-designated provider for $0.

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.

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in: Suburban Arizona, Urban Kansas, Urban Missouri, Rural Michigan, Rural Nebraska, Rural North Dakota, Suburban West Virginia, and Suburban Puerto Rico. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call **1-833-859-6031** (**TTY: 711**) or consult the online pharmacy directory at **AetnaMedicare.com/findpharmacy**.

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 **1-833-570-6670** (**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.

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.

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.

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

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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 **1-833-859-6031** (**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 **1-833-859-6031** (**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.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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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)

လၢကမၤန့ၢ် ကိြာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢၣ်ဘူၣ်လၢၣ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီလံာ်မီအံၤ အဖီခိၣ်နှၤ်တက့ၢ်. (Karen)

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

ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍ ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ, ໃຫ້ໂທຫາເບີໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

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