

Aetna Medicare Prime Care (HMO-POS)  
H5793 - 019 | \$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](tel:1-833-859-6031) (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 [1-833-570-6670](tel:1-833-570-6670) (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/H5793-019](https://www.aetna.com/H5793-019) 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 Prime Care (HMO-POS), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:  
**Rhode Island:** Kent, Providence

## What you should know

- **Plan type:** Aetna Medicare Prime Care (HMO-POS) is an HMO plan. 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.
- **Network:** Our plan has a network of select primary care providers supported by a broad, comprehensive network to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory.
- **Referrals:** Usually, your PCP must give approval before you use other network providers. You don't need a referral for emergency or urgently needed care.
- **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/H5793-019](https://www.aetnamedicare.com/H5793-019). 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	\$0 You must continue to pay your Medicare Part B premium.
Plan deductible	\$0
MOOP	\$4,500 for in-network services  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 (unlimited number of days)	\$240 per day, days 1-4; \$0 per day, days 5-90; \$0 for additional days
Outpatient hospital observation services	\$225 copay
Outpatient hospital	\$300 copay
Ambulatory surgical center	\$200 copay



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

Benefit	Your costs in our plan
PCP	\$0 copay
Specialist	\$40 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. Some covered services may have an associated cost.
Emergency and urgent care (inside the U.S.)	\$130 copay for emergency care \$40 copay for urgent care
Emergency and urgent care, including emergency ambulance (outside the U.S.)	\$130 copay for emergency care \$130 copay for urgent care \$200 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. You may have to get a **referral from your PCP** before you can receive these services.

Benefit	Your costs in our plan
Diagnostic tests and procedures	\$5 copay \$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	\$50 - \$100 copay  \$50 copay for services performed at a non-hospital facility \$100 copay for services performed at a hospital facility
Outpatient x-rays	\$0 copay



**Hearing services**

Benefit	Your costs in our plan
Diagnostic hearing exam	\$40 copay
Routine hearing exam	\$0 copay You get one routine hearing exam every year with a provider in the NationsHearing® network.
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. <ul style="list-style-type: none"> <li>• Level 1 (Standard): \$0 copay per ear, per year</li> <li>• Level 2 (Select): \$475 copay per ear, per year</li> <li>• Level 3 (Superior Plus): \$650 copay per ear, per year</li> <li>• Level 4 (Advanced): \$895 copay per ear, per year</li> <li>• Level 5 (Advanced Plus): \$1,300 copay per ear, per year</li> <li>• Level 6 (Specialty): \$1,700 copay per ear, per year</li> </ul>



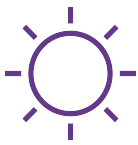
**Dental services**

Benefit	Your in-network costs	Your out-of-network costs
Dental services (non-Medicare covered)	\$0 copay for covered services  You get an annual benefit amount (allowance) of \$1,000 for covered services. You are responsible for any costs over this amount.  Covered services include oral exams, x-rays, cleanings, fillings, extractions, 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.	50% coinsurance for covered services



### Vision services

Benefit	Your costs in our plan
Diagnostic eye exam (includes diabetic eye exams)	\$0 - \$40 copay \$0 copay for diabetic eye exams \$40 copay for all other Medicare-covered eye exams
Glaucoma screening	\$0 copay
Routine eye exam (one exam every year)	\$0 copay with an EyeMed provider
Contacts and eyeglasses	You get an annual benefit amount (allowance) of \$250 for covered prescription eyewear.  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.



### 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	\$300 per day, days 1-5; \$0 per day, days 6-90 Our plan covers up to 190 days per benefit period.
Outpatient mental health therapy	\$40 copay for individual sessions \$40 copay for group sessions
Outpatient psychiatric therapy	\$40 copay for individual sessions \$40 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. You may have to get a **referral from your PCP** before you can receive these services. 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	\$10 per day, days 1-20; \$165 per day, days 21-100 Our plan covers up to 100 days per benefit period.
Physical and speech therapy	\$10 copay
Occupational therapy	\$10 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 (ground or air, one-way trip)	\$200 copay for ground ambulance services 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  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  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 (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 \$200. 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	25%	25%	25%	25%	25%
Tier 4: Non-Preferred Drug	30%	30%	30%	30%	30%
Tier 5: Specialty	30%	30%	30%	30%	30%

### 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	25%	25%	25%	25%
Tier 4: Non-Preferred Drug	30%	30%	30%	30%
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.



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### **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



### 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 an additional wallet. See the **Special Supplemental Benefits** chart for more details.

Benefit	
CVS Over-the-Counter (OTC) Wallet	<p>You get a \$75 quarterly benefit amount (allowance).</p> <p>You can use your CVS 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 participating CVS® retail locations (excluding locations inside other stores), and online or by phone through CVS OTC Health Solutions®.</p> <p><b>Important:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• If you changed plans, you may receive a new card. Do not throw away your current card unless you get a new card.</li> </ul>



### Alternative medicine

Benefit	Your costs in our plan
Acupuncture	<p>\$40 copay for Medicare-covered acupuncture visits</p> <p>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services are not covered.</p>
Chiropractic services	<p>\$0 copay for Medicare-covered chiropractic visits</p> <p>Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services are not covered.</p>



### 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	<p>0% - 20% coinsurance</p> <p>0% coinsurance for Accu-Chek/Roche and TRUE/Trividia blood glucose meters, and medical diabetic supplies</p> <p>20% coinsurance for blood glucose meters and supplies manufactured by providers other than Accu-Chek/Roche and TRUE/Trividia with an approved prior authorization</p>



### Fitness benefit

Benefit	Your costs in our plan
Annual physical fitness membership	<p>\$0 copay</p> <p>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.</p>



### Foot care (podiatry services)

You may have to get a **referral from your PCP** before you can receive these services.

Benefit	Your costs in our plan
Foot exams and treatment	<p>\$40 copay for Medicare-covered podiatry visits</p> <p>\$40 copay for non-Medicare covered podiatry visits</p> <p>For non-Medicare covered services, we cover up to twelve visits every year.</p>



### 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
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 costs in our plan
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
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	\$40 copay for individual sessions \$40 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:

If you are diagnosed with one or more of the chronic conditions listed in the EOC and meet the eligibility 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.

#### Benefits:

If you qualify, you get an **Extra Supports Wallet** with a \$30 quarterly benefit amount (allowance).

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 qualify, this wallet will be added to your current Extra Benefits 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) and/or reduced cost sharing shown below if you are diagnosed with one or more chronic conditions listed in the EOC and 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 quarterly additional benefit amount (allowance) added to your Extra Supports Wallet
- **Reduced cost shares for in-network:**
  - Medicare-covered specialist services, including podiatry: \$10 copay for each visit
  - Non-Medicare covered podiatry services: \$10 copay for each visit
  - Medicare-covered outpatient mental health therapy (individual sessions or group sessions): \$0 copay for each service
  - Medicare-covered outpatient psychiatric therapy (individual sessions or group sessions): \$0 copay for each service
  - Medicare-covered echocardiograms and stress tests: \$0 copay for each service

Prior authorization for certain services may be required and is the responsibility of your provider.

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). 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.

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](https://www.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.

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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**) (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](tel:1-833-859-6031) (TTY: [711](tel: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](https://www.aetna.com) or call [1-833-859-6031](tel:1-833-859-6031) (TTY: [711](tel: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 certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

**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 dookumentii 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)

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 ကျိၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢၣ်ဘျၣ်လၢၣ်စ့ၤ လၢန့ၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲလံာ်တီလံာ်မိအံၤ အဖီခိၣ်န့ၣ်တက့ၢ်. (Karen)

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

ເພື່ອ ໄດ້ຂາດຖົງການ ບໍລິການພາສາໂດຍ ບຸລະສອນ ວ່າ ຈໍາ າຍໃດໆ, ໃຫ້ ໂທຫາ ບົ໊ໂທໃນເອກະສານນີ້. (Laotian)

ដើម្បីទទួលបានសេវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទៅលេខដែលមាននៅលើឯកសារនេះ។ (Mon-Khmer, Cambodian)

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

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