



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=082700-060020-042376> or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$0. Out-of- <u>Network</u> : Individual \$100 / Family \$250.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency care, <u>prescription drugs</u> & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of- <u>Network</u> : Individual \$2,100 / Family \$5,250. <u>Prescription drugs</u> : Individual \$4,600 / Family \$9,200.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See http://www.aetna.com/docfind or call 1-800-370-4526 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; no charge for office surgery	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/standardoptoutaetna	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$5 for 30 day supply, \$10 for 31-90 day supply (retail); \$15 for 31-90 day supply (mail order)	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply, \$30 for 31-90 day supply (retail); \$45 for 31-90 day supply (mail order)	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 for 30 day supply, \$30 for 31-90 day supply (retail); \$45 for 31-90 day supply (mail order)	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply (retail & mail order)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Precertification required for coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of-network emergency use paid the same as in- <u>network</u> .
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of-network emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u> , <u>deductible</u> doesn't apply	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	No charge	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	120 days/calendar year in- <u>network</u> & 60 days out-of-network/calendar year. Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	Penalty of 30% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - Limited to chronic pain.
- Bariatric surgery
- Chiropractic care - 25 visits maximum/calendar year.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16.
- Infertility treatment - For more information & exceptions, see policy document using summary box link on page 1 or call the number on your ID card.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the [plan](#) at 1-800-370-4526.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church [plan](#), church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Toll-free phone: 1-888-393-1062, In-State Only, or Consumer Hotline: 1-800-446-7467, https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm.
- For non-federal governmental group health [plans](#), you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, 20 West State Street, PO Box 472, Trenton, NJ 08625-0472, 1-800-446-7467, Fax: 609-292-2431, <http://www.state.nj.us/dobi/consumer.htm>, ombudsman@dobi.state.nj.us

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$10
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$100

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።
Arabic -	مقرر الى ع لاصت الاء اجر لاء ءفلكت ي أ نود ءيوع لال اتامدخ ل الى ع لوصحلل 1-800-370-4526
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবকিসাি পপকে হকয এই নম্বকি পবেযক ান ব্রুন: 1-800-370-4526।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-800-370-4526 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Cherokee -	Ⴄႃႉႃႉ Ⴑႉႃႉႃႉ Ⴑႉႃႉႃႉ Ⴑႉႃႉႃႉ Ⴑႉႃႉႃႉ Ⴑႉႃႉႃႉ Ⴑႉႃႉႃႉ 1-800-370-4526.
Chinese -	如欲使用免費語言服務，請致電 1-800-370-4526。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.
Cushite -	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.

Gujarati -	તમારે કોઇ જાતના ખર્ચ વાનિ ભાષાની સેવિઓની પહોર માટે, કોલ કરો 1-800-370-4526.
Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526 Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लएि, 1-800-370-4526 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526.
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	M dyi wuḍu-dù kà kò dò bë dyi móuñ nì Pídyi ní, nîí, dá nòbà nà ke: 1-800-370-4526.
Kurdish -	1-800-370-4526 یەرامژ مە مەکەب یەدەنەوی مە پ، و ت و ب نو و چ ئێ ئ ب مە پ نامز یراز و گتەمەز مە ب ن ت ش ی ه گ ا ر ئ پ س ه د و ب
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕົກກັບທຶນ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-800-370-4526 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlök 1-800-370-4526.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.
Mon-Khmer Cambodian -	ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកកម្ពុជា មុននឹងទូរស័ព្ទ ទៅកាន់លេខ 1-800-370-4526។.
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo báqáh ílínígóó kojí' hólne' 1-800-370-4526.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-800-370-4526 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të kɔɔr yin wëër de thokic ke cîn wëu kɔr keek tënɔŋ yîn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-370-4526.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.

[illegible]