



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, www.mymta.info or by calling 1-646-376-0123. 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 1-646-376-0123 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | In-Network: \$0. Out-of-Network: Individual \$100 / Family \$0. | 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> ? | No. | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services |
| Are there other <u>deductibles</u> for specific services? | Yes. \$100 for <u>durable medical equipment</u> & \$50 for out-of-network <u>home health care</u> . There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | Not applicable | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Not applicable | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.aetnaNYCT.com or call 1-855-824-5943 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> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 <u>copay</u> /visit, <u>deductible</u> (DED) doesn't apply | Subject to Type D3/EMB Schedule of Allowances. | None |
| | <u>Specialist</u> visit | \$15 <u>copay</u> /visit | Subject to Type D3/EMB Schedule of Allowances. | None |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | Subject to Type D3/EMB Schedule of Allowances. | 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) | \$15 <u>copay</u> /visit | Subject to Type D3/EMB Schedule of Allowances. | None |
| | Imaging (CT/PET scans, MRIs) | \$15 <u>copay</u> /visit | Subject to Type D3/EMB Schedule of Allowances. | None |
| If you need drugs to treat your illness or condition <u>Prescription drug coverage</u> is | Generic drugs- Your Lowest-Cost Option | Retail/Specialty Medications (med): 1-30 day: \$0 <u>copay</u> ; Mail order (MOD) med: 31-90 day \$0 <u>copay</u> ; MOD Specialty med: 30 day \$0 <u>copay</u> | You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement | <u>Provider</u> means <u>network</u> pharmacy for purposes of this section. Retail: Up to a 30 day supply. MOD: Up to a 90 day supply. MOD Specialty: up to 30 day supply. |

| 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) | |
| administered by CVS Caremark More information about <u>prescription drug coverage</u> is available at www.caremark.com | Preferred brand drugs- Your Mid-Range Cost Option | Retail/Specialty Med: 1-30 day: \$20 <u>copay</u> ; MOD/Specialty Med: 31-90 day \$40 <u>copay</u> | You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement | |
| | Non-preferred brand drugs- Your Highest Cost Option | Retail/Specialty Med: 1-30 day: \$40 <u>copay</u> ; MOD Med: 31-90 day \$80 <u>copay</u> ; MOD Specialty Med: 30 day \$0 <u>copay</u> | You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement | |
| | <u>Specialty drugs</u> | Applicable cost as noted above for generic or brand drugs | You will pay the cost of the med & submit a paper <u>claim</u> for possible reimbursement | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Subject to Type D3/EMB Schedule of Allowances. | None |
| | Physician/surgeon fees | No charge | Subject to Type D3/EMB Schedule of Allowances. | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$100 copay per visit | \$100 copay per visit | No coverage for non-emergency use. |
| | <u>Emergency medical transportation</u> | No charge | No charge | Non-emergency transport: not covered, except if pre-authorized. |
| | <u>Urgent care</u> | \$15 <u>copay</u> /visit | \$15 <u>copay</u> /visit, deductible doesn't apply | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$50 <u>copay</u> /stay | Subject to Type D3/EMB Schedule of Allowances. | Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care. |

| 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) | |
| | Physician/surgeon fees | No charge | Subject to Type D3/EMB Schedule of Allowances. | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: \$15 <u>copay</u> /visit | Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances. | None |
| | Inpatient services | \$50 <u>copay</u> /stay | 0% <u>coinsurance</u> | Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If you are pregnant | Office visits | No charge | Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances. | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
| | Childbirth/delivery professional services | No charge | Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances. | |
| | Childbirth/delivery facility services | \$50 <u>copay</u> /stay | Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances. | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 25% <u>coinsurance</u> , after specific <u>deductible</u> | 200 visits/calendar year in- <u>network</u> & 40 visits/calendar year out-of-network. Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care. |

| 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) | |
| | <u>Rehabilitation services</u> | \$15 <u>copay</u> /visit | Subject to Type D3/EMB Schedule of Allowances. | Physical and occupational therapy each limited to 20 visits/calendar year unless additional visits are medically necessary. |
| | <u>Habilitation services</u> | \$15 <u>copay</u> /visit | Subject to Type D3/EMB Schedule of Allowances. | Limited to treatment of Autism. |
| | <u>Skilled nursing care</u> | No charge | Subject to Type D3/EMB Schedule of Allowances. | 100 days/calendar year. Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | <u>Durable medical equipment</u> | 0% <u>coinsurance</u> , after specific <u>deductible</u> | 50% <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 | Subject to Type D3/EMB Schedule of Allowances. | Penalty of \$250/day (up to \$500) 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 | No charge | Subject to Type D3/EMB Schedule of Allowances. | 1 routine eye exam/calendar year |
| | 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 | • Hearing aids | • Routine eye care (Adult & Child) |
| • Dental care (Adult & Child) | • Long-term care | • Routine foot care |
| • Glasses (Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

- | | | |
|---------------------|-------------------------|------------------------|
| • Acupuncture | • Chiropractic care | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | |

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:

- For more information on your rights to continue coverage, contact the plan at 1-646-376-0123.
- 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 <http://www.dol.gov/ebsa/healthreform>
- 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-646-376-0123.
- 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 <http://www.dol.gov/ebsa/healthreform>
- 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 information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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</u> <u>copayment</u> | \$15 |
| ■ Hospital (facility) <u>copayment</u> | \$50 |
| ■ 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> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$260 |

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</u> <u>copayment</u> | \$15 |
| ■ Hospital (facility) <u>copayment</u> | \$50 |
| ■ 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
Durable medical equipment (*glucose meter*)

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles*</u> | \$0 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$420 |

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</u> <u>copayment</u> | \$15 |
| ■ Hospital (facility) <u>copayment</u> | \$50 |
| ■ 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> | \$80 |
| <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$80 |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-646-376-0123.

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, or disability.

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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

Language Assistance:

| | |
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| Albanian - | Për asistencë në gjuhën shqipe telefononi falas në 1-646-376-0123. |
| Amharic - | ለቋንቋ እገዛ በ አማርኛ በ 1-646-376-0123 በነጻ ይደውሉ |
| Arabic - | 1-646-376-0123 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني |
| Armenian - | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-646-376-0123 առանց գնով: |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-646-376-0123 tanpa dikenakan biaya. |
| Bantu-Kirundi - | Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-646-376-0123 ku busa |
| Bengali-Bangala - | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-646-376-0123-তে কল করুন। |
| Bisayan-Visayan - | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-646-376-0123 nga walay bayad. |
| Burmese - | ငွေတန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-646-376-0123 ကို ခေါ်ဆိုပါ။ |
| Catalan - | Per rebre assistència en (català), truqui al número gratuït 1-646-376-0123. |
| Chamorro - | Para ayuda gi fino' (Chamoru), ágang 1-646-376-0123 sin gástu. |
| Cherokee - | ᏅᏍᏔᏅ ᏌᏍᏊᏂᏍᏔᏅ ᏊᏂᏍᏔᏅᏍᏔᏅ ᏅᏍᏔᏅ (GWY) ᏅᏍᏔᏅᏍᏔᏅ 1-646-376-0123 ᏅᏍᏔᏅ Ꮜ ᏅᏍᏔᏅ ᏊᏂᏍᏔᏅ ᏂᏍᏔᏅ. |
| Chinese - | 欲取得繁體中文語言協助，請撥打1-646-376-0123，無需付費。 |
| Choctaw - | (Chahta) anumpa ya apela a chi l paya hinla 1-646-376-0123. |
| Cushite - | Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsaa bilbilaa 1-646-376-0123 irratti bilisaan bilbilaa. |
| Dutch - | Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-646-376-0123. |
| French - | Pour une assistance linguistique en français appeler le 1-646-376-0123 sans frais. |
| French Creole - | Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-646-376-0123 gratis. |
| German - | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-646-376-0123 an. |
| Greek - | Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-646-376-0123 χωρίς χρέωση. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-646-376-0123 પર કોલ કરો. |
| Hawaiian - | No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-646-376-0123. Kāki ‘ole ‘ia kēia kōkua nei. |

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|------------------------|--|
| Hindi - | हन्दिी में भाषा सहायता के लिए, 1-646-376-0123 पर मुफ्त कॉल करें। |
| Hmong - | Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-646-376-0123. |
| Ibo - | Maka enyemaka asụsụ na Igbo kpọọ 1-646-376-0123 na akwughị ugwo ọ bụla |
| Ilocano - | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-646-376-0123 nga awan ti bayadanyo. |
| Italian - | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-646-376-0123. |
| Japanese - | 日本語で援助をご希望の方は、1-646-376-0123 まで無料でお電話ください。 |
| Karen - | လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အီၣ် ၁-၆၄၆-၃၇၆-၀၁၂၃ လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်သ့ၣ်လၢၢ်စ့ၤ |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-646-376-0123 번으로 전화해 주십시오. |
| Kru-Bassa - | Be'm'ké gbo-kpá-kpá dyé pidyi dé Baśwó'-wuḍuñ wěě, dā 1-646-376-0123 |
| Kurdish - | برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 به خۆرای یه یۆمندی بکهن. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທ771-646-376-0123 ໂດຍບໍ່ເສຍຄ່າໂທ. |
| Marathi - | कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-646-376-0123 वर फोन करा. |
| Marshallese - | Nān bōk jipañ ilo Kajin Majol, kallok 1-646-376-0123 ilo ejjelok wōnān. |
| Micronesian - | |
| Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-646-376-0123 ni sohte isais. |
| Mon-Khmer, Cambodian - | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-646-376-0123 ដោយឥតគិតថ្លៃ។ |
| Navajo - | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-646-376-0123 |
| Nepali - | (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-646-376-0123 मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tën kuwoɲy è thok ë Thuonjäŋ cöl 1-646-376-0123 kec'in ayöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-646-376-0123 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-646-376-0123 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Hilfe in Deutsch, ruf: 1-646-376-0123 aa. Es Aaruf koschtet nix. |
| Persian - | برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 بدون هیچ هزینه ای تماس بگیرید. انگلیسی |
| Polish - | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-646-376-0123. |
| Portuguese - | Para obter assistência linguística em português ligue para o 1-646-376-0123 gratuitamente. |
| Romanian - | Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-646-376-0123 |

[illegible]