

 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, call 1-855-706-7545 or visit [www.CareConnect.com](http://www.CareConnect.com). 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-706-7545 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 person / \$300 family for <a href="#">prescription drugs</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For participating <a href="#">providers</a> \$1,000 individual / \$2,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges (unless balance-billing is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.CareConnect.com">www.CareConnect.com</a> or call 1-855-706-7545 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	-----None-----
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	-----None-----
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copay</a> / test; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , services will not be covered.*
	Imaging (CT/PET scans, MRIs)	\$30 <a href="#">copay</a> / test; <a href="#">deductible</a> does not apply	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.careconnect.com/find-resources/prescription-drug-information">www.careconnect.com/find-resources/prescription-drug-information</a>	Tier 1 (Generic Drugs)	\$15 <a href="#">copay</a> / retail prescription; <a href="#">deductible</a> does not apply	Not Covered	Covers up to a 30-day supply. <a href="#">Copay</a> for up to a 90 day supply is three times the regular <a href="#">copay</a> at retail and two and a half times the regular <a href="#">copay</a> at mail order. <a href="#">Preauthorization</a> is required for certain drugs. If you don't get <a href="#">preauthorization</a> , these drugs will not be covered.*
	Tier 2 (Preferred brand drugs)	\$35 <a href="#">copay</a> after Rx <a href="#">deductible</a> / retail prescription	Not Covered	
	Tier 3 (Non-preferred brand drugs and Specialty drugs)	\$75 <a href="#">copay</a> after Rx <a href="#">deductible</a> / retail prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 <a href="#">copay</a> / procedure; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , services will not be covered.*
	Physician/surgeon fees	No charge; <a href="#">deductible</a> does not apply	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.CareConnect.com](http://www.CareConnect.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	\$200 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	-----None-----
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a> / transport; <a href="#">deductible</a> does not apply	\$100 <a href="#">copay</a> / transport; <a href="#">deductible</a> does not apply	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> / admission; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , services will not be covered.*
	Physician/surgeon fees	No charge; <a href="#">deductible</a> does not apply	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Non-routine outpatient services may require <a href="#">preauthorization</a> . If you don't get required <a href="#">preauthorization</a> , services will not be covered.*
	Inpatient services	\$500 <a href="#">copay</a> / admission; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required except for emergency admissions or for Participating OASAS-certified facilities. If you don't get <a href="#">preauthorization</a> , services will not be covered.*
If you are pregnant	Office visits	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply; no charge for prenatal and postnatal care	Not covered	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , services will not be covered. All breast pumps require a <a href="#">preauthorization</a> . * <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) One (1) Home Care Visit is Covered at no <a href="#">cost sharing</a> if mother is discharged from the hospital early.
	Childbirth/delivery professional services	No charge; <a href="#">deductible</a> does not apply	Not covered	
	Childbirth/delivery facility services	\$500 <a href="#">copay</a> / admission and no charge for physician services; <a href="#">deductible</a> does not apply	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.CareConnect.com](http://www.CareConnect.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 40 visits per plan year. <a href="#">Preauthorization</a> is required. If you don't get required <a href="#">preauthorization</a> , services will not be covered.*
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 60 visits per condition, per <a href="#">plan</a> year combined therapies. Speech and Physical Therapy are only covered following a hospital stay or surgery. <a href="#">Preauthorization</a> is required. If you don't get required <a href="#">preauthorization</a> , services will not be covered.*
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 60 visits per condition, per <a href="#">plan</a> year combined therapies. <a href="#">Preauthorization</a> is required. If you don't get required <a href="#">preauthorization</a> , services will not be covered.*
	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copay</a> / admission; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 200 days per <a href="#">plan</a> year. <a href="#">Preauthorization</a> is required. If you don't get required <a href="#">preauthorization</a> , services will not be covered.*
	<a href="#">Durable medical equipment</a>	\$200 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required. If you don't get required <a href="#">preauthorization</a> , services will not be covered. Coverage is for standard equipment only. Over the counter durable medical equipment is not covered.*
	<a href="#">Hospice services</a>	Inpatient: \$500 <a href="#">copay</a> / admission Outpatient: \$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not Covered	Coverage is limited to 210 days per <a href="#">plan</a> year and 5 visits of family bereavement counseling. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , services will not be covered.*

\* For more information about limitations and exceptions, see the plan or policy document at [www.CareConnect.com](http://www.CareConnect.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Coverage is limited to one exam per <a href="#">plan</a> year for members through the end of the month in which they turn 19 years of age.
	Children's glasses	10% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	Coverage is limited to one prescribed lenses and frames per <a href="#">plan</a> year for members through the end of the month in which they turn 19 years of age. Non-standard frames incur additional cost.
	Children's dental check-up	\$30 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Coverage is limited to one exam and one cleaning per 6 month period for members through the end of the month in which they turn 19 years of age. Please refer to the Pediatric Dental Care section of your <a href="#">plan</a> or policy document for additional coverage information.

\* For more information about limitations and exceptions, see the plan or policy document at [www.CareConnect.com](http://www.CareConnect.com).

## 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)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care(Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Abortion Services (elective abortions are limited to one procedure per member per [plan](#) year)
- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (requires a written recommendation by a physician; a single purchase includes repair and/or replacement of hearing aids for one (1) or both ears once every three (3) years; bone anchored hearing aids have additional limitations)\*.
- Infertility Treatment (limited to individuals between ages 21 and 44 inclusive; in vitro fertilization, costs for a donor, storage costs, reversal of sterilization, surrogate motherhood, cloning, and experimental procedures are not covered; additional limitations apply\*)

All of these listed services require prior authorization. If you don't get required preauthorization, services will not be covered.\*

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or visit [www.cciio.cms.gov](http://www.cciio.cms.gov); New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or visit [www.dfs.ny.gov](http://www.dfs.ny.gov); or please call CareConnect at 1-855-706-7545 or visit [CareConnect.com](http://CareConnect.com).

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](http://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 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: CareConnect at 1-855-706-7545 or visit [CareConnect.com](http://CareConnect.com); New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or visit [www.dfs.ny.gov](http://www.dfs.ny.gov); or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates at 1-888-614-5400, e-mail [cha@cssny.org](mailto:cha@cssny.org) or visit [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum essential coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

\* For more information about limitations and exceptions, see the plan or policy document at [www.CareConnect.com](http://www.CareConnect.com).

**Does this plan meet Minimum Value Standards? Yes.**

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

**Language Access Services:**

If you are in need of language assistance, please reference the multi-language taglines and nondiscrimination notification at the end of this document, or call us at 855-706-7545.

-----*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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">Plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">Plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">Plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">copayment</a>	\$500	■ Hospital (facility) <a href="#">copayment</a>	\$500	■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">copayment</a>	\$30	■ Other <a href="#">copayment</a>	\$30	■ Other <a href="#">copayment</a>	\$30
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles*	\$0	Deductibles	\$0
Copayments	\$1,000	Copayments	\$1,000	Copayments	\$900
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,060</b>	<b>The total Joe would pay is</b>	<b>\$1,060</b>	<b>The total Mia would pay is</b>	<b>\$900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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## Notice of Non-Discrimination

CareConnect Insurance Company, Inc. ("CareConnect") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CareConnect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### CareConnect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CareConnect's Senior Director, Quality Improvement.

If you believe that CareConnect has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CareConnect  
Senior Director, Quality Improvement  
2200 Northern Blvd., Suite 104, East Hills, NY 11548  
Phone: 855-706-7545  
TTY: 855-226-7318  
Fax: 844-447-2525  
Email: [CareConnectAppeals@nsljcc.com](mailto:CareConnectAppeals@nsljcc.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Senior Director, Quality Improvement is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building, Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Multi-Language Interpreter Services

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-855-226-7318 (TTY: 711).

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-226-7318 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務. 請致電 1-855-226-7318 (TTY: 711).

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-226-7318 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-226-7318 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-226-7318 (TTY: 711) 번으로 전화해 주십시오.

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-226-7318 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-226-7318 (TTY: 711).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-226-7318 (TTY: 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-226-7318 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-226-7318 (رقم هاتف الصم والبكم: 711).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-226-7318 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-855-226-7318 (TTY: 711)

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-226-7318 (TTY: 711).

**ΠΡΟΣΟΧΗ:** Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-226-7318 (TTY: 711).

**KUJDES:** Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-226-7318 (TTY: 711).

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