



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.mvphealthcare.com](http://www.mvphealthcare.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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-942-7797 to request a copy.

| Important Questions                                                             | Answers                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | In-Network -\$3,500 individual /\$7,000 family<br>Out-of-Network -\$7,000 individual /\$14,000 family.                            | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.                                                                                                                                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive care services are covered before you meet your deductible.                                                        | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                    |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                               | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In-Network -\$7,000 individual /\$14,000 family<br>Out-of-Network -\$14,000 individual /\$28,000 family                           | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Copayments for certain services, premiums, balance-billing charges, and healthcare this plan doesn't cover.                       | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> or call 1-866-942-7797 for a list of network providers. | You pay the least if you use a provider in the Preferred Provider tier. You pay more if you use a provider in the In-Network tier. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                               | You can see the specialist you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                                                             |



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                                                                                                      |
|------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Preferred Network Provider<br>(You will pay the least)                                                                                                                                                                    | In-Network Provider<br>(You will pay more)                                                                                                                                                                                  | Out-of-Network Provider<br>(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% coinsurance Deductible applies                                                                                                                                                                                        | 30% coinsurance Deductible applies                                                                                                                                                                                          | 50% coinsurance Deductible applies                 | 0% Coins. after Ded. to age 19                                                                                                                              |
|                                                                        | <a href="#">Specialist</a> visit                       | 30% coinsurance Deductible applies                                                                                                                                                                                        | 30% coinsurance Deductible applies                                                                                                                                                                                          | 50% coinsurance Deductible applies                 | None                                                                                                                                                        |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                                                                                                                 | No charge                                                                                                                                                                                                                   | 50% coinsurance Deductible applies                 | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a><br>(x-ray, blood work) | Lab Office - 30% coinsurance Deductible applies;<br>Lab Facility - 0% coinsurance Deductible applies;<br>Radiology Office - 30% coinsurance Deductible applies;<br>Radiology Facility - 0% coinsurance Deductible applies | Lab Office - 30% coinsurance Deductible applies;<br>Lab Facility - 30% coinsurance Deductible applies;<br>Radiology Office - 30% coinsurance Deductible applies;<br>Radiology Facility - 30% coinsurance Deductible applies | 50% coinsurance Deductible applies                 | Lab Office - None;<br>Lab Facility - None;<br>Radiology Office - None;<br>Radiology Facility - None                                                         |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | Office - 30% coinsurance Deductible applies;<br>Facility - 0% coinsurance Deductible applies                                                                                                                              | Office - 30% coinsurance Deductible applies;<br>Facility - 30% coinsurance Deductible applies                                                                                                                               | 50% coinsurance Deductible applies                 | Prior authorization required for non-participating provider                                                                                                 |

| Common Medical Event                                                                                                                             | Services You May Need                             | What You Will Pay                                             |                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                  |                                                   | Preferred Network Provider<br>(You will pay the least)        | In-Network Provider<br>(You will pay more)                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at | Tier 1<br>(Generic drugs)                         | Not covered                                                   | Not covered                                                   | Not covered                                        | SUD and Fertility Drugs only - 30 day supply retail takes PCP Copay; Mail Order, takes 3 x PCP Copay, Up to a 90-day supply |
|                                                                                                                                                  | Tier 2<br>(Preferred brand drugs)                 | Not covered                                                   | Not covered                                                   | Not covered                                        | None                                                                                                                        |
|                                                                                                                                                  | Tier 3<br>(Non-preferred brand drugs)             | Not covered                                                   | Not covered                                                   | Not covered                                        | None                                                                                                                        |
|                                                                                                                                                  | Tier 4<br><a href="#">Specialty drugs</a>         | Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes | Retail Covered as noted in Tier 1, Tier 2, and Tier 3 classes | Not covered                                        | None                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                            | Facility fee<br>(e.g., ambulatory surgery center) | 0% coinsurance Deductible applies                             | 30% coinsurance Deductible applies                            | 50% coinsurance Deductible applies                 | Prior authorization required for non-participating provider                                                                 |
|                                                                                                                                                  | Physician/surgeon fees                            | 30% coinsurance Deductible applies                            | 30% coinsurance Deductible applies                            | 50% coinsurance Deductible applies                 | Prior auth required for non-par                                                                                             |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                      |                                            |                                                    | Limitations, Exceptions, & Other Important Information                                       |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------|--------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Preferred Network Provider<br>(You will pay the least) | In-Network Provider<br>(You will pay more) | Out-of-Network Provider<br>(You will pay the most) |                                                                                              |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 30% coinsurance Deductible applies                 | None                                                                                         |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 30% coinsurance Deductible applies                 | None                                                                                         |
|                                                                           | <a href="#">Urgent care</a>                      | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 30% coinsurance Deductible applies                 | None                                                                                         |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 50% coinsurance Deductible applies                 | Prior Authorization required for non-participating provider                                  |
|                                                                           | Physician/surgeon fees                           | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 50% coinsurance Deductible applies                 | Prior auth required for non-par                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 50% coinsurance Deductible applies                 | Prior Authorization required for non-participating provider                                  |
|                                                                           | Inpatient services                               | 30% coinsurance Deductible applies                     | 30% coinsurance Deductible applies         | 50% coinsurance Deductible applies                 | Including residential treatment. Prior Authorization required for non-participating provider |

| Common Medical Event                                           | Services You May Need                                              | What You Will Pay                                                                            |                                                                                              |                                                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                            |
|----------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                                                    | Preferred Network Provider<br>(You will pay the least)                                       | In-Network Provider<br>(You will pay more)                                                   | Out-of-Network Provider<br>(You will pay the most)                                           |                                                                                                                                                                                                                                                   |
| If you are pregnant                                            | Office visits                                                      | No charge                                                                                    | No charge                                                                                    | 50% coinsurance<br>Deductible applies                                                        | Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay, coinsurance, and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                | Childbirth/delivery professional services                          | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           |                                                                                                                                                                                                                                                   |
|                                                                | Childbirth/delivery facility services                              | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           |                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>                                   | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           | 100 visits per Plan Year. Prior auth required for non-par                                                                                                                                                                                         |
|                                                                | <a href="#">Rehabilitation services/<br/>Habilitation services</a> | OP ReHab: 30% coinsurance Deductible applies<br>IP ReHab: 30% coinsurance Deductible applies | OP ReHab: 30% coinsurance Deductible applies<br>IP ReHab: 30% coinsurance Deductible applies | OP ReHab: 50% coinsurance Deductible applies<br>IP ReHab: 50% coinsurance Deductible applies | OP ReHab: 60 combined PT/OT/ST visits per year<br>IP ReHab: 30 days per Plan Year combined therapies. Prior Auth required for non-participating provider                                                                                          |
|                                                                | <a href="#">Skilled nursing care</a>                               | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           | 120 days per Plan Year. Prior Authorization required for non-participating provider                                                                                                                                                               |
|                                                                | <a href="#">Durable medical equipment</a>                          | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           | None                                                                                                                                                                                                                                              |
|                                                                | <a href="#">Hospice services</a>                                   | 30% coinsurance Deductible applies                                                           | 30% coinsurance Deductible applies                                                           | 50% coinsurance Deductible applies                                                           | 5 visits for family bereavement counseling                                                                                                                                                                                                        |

| Common Medical Event                   | Services You May Need      | What You Will Pay                                      |                                            |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------|--------------------------------------------------------|--------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                            | Preferred Network Provider<br>(You will pay the least) | In-Network Provider<br>(You will pay more) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If your child needs dental or eye care | Children's eye exam        | Not covered                                            | Not covered                                | Not covered                                        | None                                                   |
|                                        | Children's glasses         | Not covered                                            | Not covered                                | Not covered                                        | None                                                   |
|                                        | Children's dental check-up | Not covered                                            | Not covered                                | Not covered                                        | None                                                   |

#### 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](#).)

- Children's Dental Check-up
- Children's Eye exam
- Children's Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Generic drugs
- Long-Term Care
- Non-Emergency care when traveling outside the U.S
- Non-preferred brand drugs
- Preferred brand drugs
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Specialty drugs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Weight Loss Programs

**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:

MVP Health Care  
P.O. Box 2207  
Schenectady, NY 12301  
Toll Free: 1-888-687-6277  
[www.mvphealthcare.com](http://www.mvphealthcare.com)  
[members@mvphealthcare.com](mailto:members@mvphealthcare.com)

You can also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa](http://dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov). 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](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:

MVP Health Care  
Attn: Member Appeals  
P.O.Box 2207  
Schenectady, NY 12301  
Toll Free:1-866-942-7797  
[www.mvphealthcare.com](http://www.mvphealthcare.com)  
[members@mvphealthcare.com](mailto:members@mvphealthcare.com)

You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or the NYS Department of Insurance at 1-800-342-3736 or [dfs.ny.gov](http://dfs.ny.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Community Health Advocates at 1-888-614-5400 or [communityhealthadvocates.org](http://communityhealthadvocates.org).

**Does this plan provide Minimum Essential Coverage?** No.

[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 the Minimum Value Standards?** No.

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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,400 |
| ■ <a href="#">Specialist</a> Coinsurance                        | 30%     |
| ■ <a href="#">Hospital (facility)</a> Coinsurance               | 30%     |
| ■ <a href="#">Other</a> Coinsurance                             | 30%     |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,400        |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,300        |
| What isn't covered                |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$5,770</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,400 |
| ■ <a href="#">Specialist</a>                                    | 30%     |
| ■ <a href="#">Hospital (facility)</a>                           | 30%     |
| ■ <a href="#">Other</a>                                         | 30%     |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,400        |
| Copayments                        | \$0            |
| Coinsurance                       | \$600          |
| What isn't covered                |                |
| Limits or exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$4,030</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,400 |
| ■ <a href="#">Specialist</a>                                    | 30%     |
| ■ <a href="#">Hospital (facility)</a>                           | 30%     |
| ■ <a href="#">Other</a>                                         | 30%     |

#### This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,800        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

# Language Assistance



ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call **1-844-946-8010** (TTY 711).

English

ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al **1-844-946-8010** (TTY 711).

Español  
(Spanish)

请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 **1-844-946-8010** (TTY 711)。

繁體中文  
(Chinese)

**1-844-946-8010** (TTY 711)

لعرربة

ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم

(Arabic)

주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다 **1-844-946-8010** (TTY 711). 번으로 연락해 주십시오.

한국어  
(Korean)

ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру **1-844-946-8010** (TTY 711).

Русский  
(Russian)

ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il **1-844-946-8010** (TTY 711).

Italiano  
(Italian)

ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le **1-844-946-8010** (TTY 711).

Français  
(French)

|                                                                                                                                      |                                |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele <b>1-844-946-8010</b> (TTY 711).             | Kreyòl Ayisyen (French Creole) |
| אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופ <b>1-844-946-8010</b> (TTY 711).                 | אידיש (Yiddish)                |
| UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: <b>1-844-946-8010</b> (TTY 711).                       | Polski (Polish)                |
| ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa <b>1-844-946-8010</b> (TTY 711).     | Tagalog (Tagalog-Filipino)     |
| মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। <b>1-844-946-8010</b> (TTY 711)-এ ফোন করুন।             | বাংলা (Bengali)                |
| VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi <b>1-844-946-8010</b> (TTY 711).       | Shqip (Albanian)               |
| ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο <b>1-844-946-8010</b> (TTY 711). | Ελληνικά (Greek)               |
| توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں <b>1-844-946-8010</b> (TTY 711)۔  | اردو (Urdu)                    |