

 **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 healthcare 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, including a copy of the Fund’s [Summary Plan Description \(SPD\)](#), call (646) 473-9200 or visit www.1199SEIUBenefits.org. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [co-insurance](#), [co-payment](#), [deductible](#), [provider](#) or other [underlined](#) terms, see the Glossary. You can view the Glossary at www.1199SEIUBenefits.org or call (646) 473-9200 to request a copy.

Eligible members receive **all** of the benefits listed below for **themselves and their enrolled children**.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	This plan covers all items and services without a deductible . But a co-payment may apply.
Are there other deductibles for specific services?	No.	You don’t have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.1199SEIUBenefits.org or call (646) 473-9200 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan’s network . 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 referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All co-payment and co-insurance 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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	\$5 <u>co-pay</u> /visit	\$5 <u>co-pay</u> /visit, plus <u>provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	<u>Specialist</u> visit	\$5 <u>co-pay</u> /visit	\$5 <u>co-pay</u> /visit, plus <u>provider</u> charges	Allergy: Up to 20 treatments/year, including <u>diagnostic testing</u> Dermatology: Up to 20 treatments/year If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	<u>Preventive care</u> / <u>screening</u> / immunization	\$5 <u>co-pay</u> /visit	\$5 <u>co-pay</u> /visit, plus <u>provider</u> charges	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	No charge	<u>Provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	Imaging (CT/PET scans, MRIs, MRAs)	No charge	<u>Provider</u> charges	<u>Prior approval</u> is required. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered. If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.1199SEIUBenefits.org	Generic drugs	\$3 <u>co-pay</u> /retail prescription \$6 <u>co-pay</u> / mail-order prescription	<u>Provider</u> charges	<u>Participating Providers</u> are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the <u>provider</u> bills above the Fund's payment. For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price.
	Preferred brand drugs	\$6 <u>co-pay</u> /retail prescription \$12 <u>co-pay</u> / mail-order prescription	<u>Provider</u> charges	<u>Prior approval</u> is required for certain medications. Certain medications are subject to clinical program management. Prescriptions for chronic conditions must be filled through <i>The 1199SEIU 90-Day Rx Solution</i> . Medications that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered. For limitations, exceptions and other important information, see the <u>SPD</u> at www.1199SEIUBenefits.org .

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 drugs to treat your illness or condition (continued) More information about prescription drug coverage is available at www.1199SEIUBenefits.org	Non-preferred brand drugs	\$6 <u>co-pay</u> /retail prescription \$12 <u>co-pay</u> /mail-order prescription You will be charged a differential in addition to your <u>co-pay</u> .	<u>Provider charges</u>	<p><u>Participating Providers</u> are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p> <p>For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price.</p> <p><u>Prior approval</u> is required for certain medications. Certain medications are subject to clinical program management.</p> <p>Prescriptions for chronic conditions must be filled through <i>The 1199SEIU 90-Day Rx Solution</i>.</p> <p>Medications that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered. For limitations, exceptions and other important information, see the <u>SPD</u> at www.1199SEIUBenefits.org.</p>
	<u>Specialty drugs</u>	Generic and brand <u>co-pays</u> apply (see page 2). You will be charged a differential for non-preferred brand drugs.	<u>Provider charges</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for use of facility	<u>Provider charges</u>	<p><u>Prior approval</u> is required for certain procedures. Procedures that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>
	<u>Physician/surgeon fees</u>	No charge	<u>Provider charges</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$3 <u>co-pay</u> if not admitted to hospital	\$3 <u>co-pay</u> if not admitted to hospital, plus <u>provider charges</u>	<p>A hospital <u>emergency room</u> should be used only in the case of a legitimate medical emergency, and must occur within 72 hours of an injury or the onset of a sudden and serious illness. If you go to a Non-Participating Hospital <u>emergency room</u>, you may incur additional <u>out-of-pocket</u> costs.</p> <p>Use of <u>emergency medical transportation</u> in non-emergency situations is not covered.</p> <p>If you use an <u>emergency medical transportation provider</u> with which the Fund does not have a contract, you may incur additional <u>out-of-pocket</u> costs.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>
	<u>Emergency medical transportation</u>	No charge	<u>Provider charges</u>	
	<u>Urgent care</u>	No charge	<u>Provider charges</u>	

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 have a hospital stay	Facility fee (e.g., hospital room)	\$25 <u>co-pay</u> /admission	\$25 <u>co-pay</u> /admission, plus <u>provider</u> charges	<p><u>Prior approval</u> is required for non-emergency admissions. Admissions that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Notification is required within 48 hours of an emergency admission.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
	<u>Physician/surgeon</u> fees	No charge	<u>Provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
If you need mental health, behavioral health or substance abuse services	Outpatient services	No charge	<u>Provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	Inpatient services	\$25 <u>co-pay</u> /admission	\$25 <u>co-pay</u> /admission, plus <u>provider</u> charges	<p><u>Prior approval</u> is required for non-emergency admissions, partial <u>hospitalization</u> programs and intensive outpatient programs. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Notification is required within 48 hours of an emergency admission.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
If you are pregnant	Office visits	No charge	<u>Provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	Childbirth/delivery professional services	No charge	<u>Provider</u> charges	If you use a <u>Non-Participating Provider</u> , you may be charged the amount the <u>provider</u> bills above the Fund's payment.
	Childbirth/delivery facility services	\$25 <u>co-pay</u> /admission	\$25 <u>co-pay</u> /admission, plus <u>provider</u> charges	<p><u>Prior approval</u> is required for inpatient stays longer than 48 hours (natural delivery) or 96 hours (cesarean delivery). Stays exceeding the above time frames that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p><u>Prior approval</u> is required for hospital-grade breastfeeding equipment. Equipment that is not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Lactation consulting is limited to three visits and is covered only when provided by certified <u>providers</u>. If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p> <p><u>Cost sharing</u> does not apply for certain <u>preventive services</u>. Depending on the type of services, <u>co-payments</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</p>

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	<u>Home health care</u>	No charge	<u>Provider</u> charges	<p><u>Prior approval</u> is required. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Coverage is limited to 60 visits/year based on <u>medical necessity</u>.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
	<u>Rehabilitation services</u>	\$5 <u>co-pay</u> /outpatient visit \$25 <u>co-pay</u> /inpatient admission	\$5 <u>co-pay</u> /outpatient visit, plus <u>provider</u> charges \$25 <u>co-pay</u> /inpatient admission, plus <u>provider</u> charges	<p><u>Prior approval</u> is required for inpatient <u>rehabilitation</u>. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Coverage for inpatient <u>rehabilitation</u> is limited to 30 days/year in a hospital for acute care.</p> <p>Coverage for outpatient physical/occupational/speech therapy is limited to 25 visits/discipline/year. <u>Prior approval</u> is required for additional visits. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
	<u>Habilitation services</u>	\$5 <u>co-pay</u> /visit	\$5 <u>co-pay</u> /visit, plus <u>provider</u> charges	<p>Coverage is for outpatient <u>habilitation services</u> only.</p> <p>Coverage for physical/occupational/speech therapy is limited to 25 visits/discipline/year. <u>Prior approval</u> is required for additional visits. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
	<u>Skilled nursing care</u>	No charge	<u>Provider</u> charges	<p><u>Prior approval</u> is required. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>
	<u>Durable medical equipment</u>	No charge	<u>Provider</u> charges	<p><u>Prior approval</u> is required for certain items. Items that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Excludes vehicle modifications, home modifications, exercise and bathroom equipment.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider</u> bills above the Fund's payment.</p>

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 (continued)	Hospice services	No charge	Provider charges	<p><u>Prior approval</u> is required for inpatient <u>hospice services</u>. Services that are not <u>pre-approved</u> in accordance with the terms of the <u>SPD</u> will not be covered.</p> <p>Coverage is limited to 210 days of <u>hospice care</u>/lifetime in a Medicare-certified <u>hospice program</u> in a <u>hospice center</u>, hospital, <u>skilled nursing facility</u> or for outpatient home services provided by an accredited <u>hospice organization</u>.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>
If your child needs dental or eye care	Children's eye exam	No charge when using a <u>Participating Provider</u> in the Vision Care <u>network</u>	Provider charges. You are eligible to receive a reimbursement of \$18.	<p>Maximum of one exam every two years.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>
	Children's glasses/contact lenses	No charge for frames or lenses that are included in the Fund's program	Provider charges. You are eligible to receive a reimbursement of \$57.	<p>Coverage is limited to one pair of Fund program prescription glasses or one order of contact lenses every two years.</p> <p>Payment for exam and glasses or contact lenses that are not included in the Fund's program will be limited up to the Fund's allocation of \$75.</p> <p>Scratch-resistant and ultraviolet lens treatments are not covered.</p> <p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>
	Children's dental check-up	No charge	Provider charges	<p>If you use a <u>Non-Participating Provider</u>, you may be charged the amount the <u>provider bills</u> above the Fund's payment.</p>

Excluded Services and Other Covered Services:

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

- Care provided in a skilled nursing facility or nursing home
- Cosmetic surgery
- Habilitation services to the extent coverage is available from any other sources
- Infertility treatment
- Long-term care
- Weight-loss programs

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

- Abortion services
- Acupuncture by licensed medical physicians: Coverage limited to 25 treatments/year; \$5 co-pay/treatment
- Bariatric surgery (subject to prior approval)
- Chiropractic care: Coverage limited to 12 treatments/year; \$5 co-pay/treatment
- Dental care (adult): Co-pays may apply
- Hearing aids: Once every three years (co-pays may apply); Maximum benefit of \$750 (\$375 for each ear)
- Non-emergency care when traveling outside the U.S. (some restrictions may apply)
- Private-duty nursing (subject to prior approval and some restrictions apply)
- Routine eye care (adult): One eye exam every two years; One pair of glasses or one order of contact lenses every two years
- Routine foot care: Coverage limited to 15 treatments/year; \$5 co-pay/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: The Fund's plan at (646) 473-9200. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight at (877) 267-2323 x61565 or www.cciio.cms.gov. 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 (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 grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: The Fund's Appeals Department at (646) 473-8951. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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.

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.

Language Access Services: Para obtener asistencia en español, llame al (646) 473-9200.

-----*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, co-payments and co-insurance) 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 prenatal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist co-payment	\$0
■ Hospital (facility) co-insurance*	\$25
■ Other co-insurance	0%

This EXAMPLE event includes services like:

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>)	
Total Example Cost	\$12,800

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Co-payments	\$60
Co-insurance	\$0
<i>What Isn't Covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$70

*Hospital facility co-payment

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist co-payment	\$10
■ Hospital (facility) co-insurance	0%
■ Other co-insurance	0%

This EXAMPLE event includes services like:

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>)	
Total Example Cost	\$7,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Co-payments	\$400
Co-insurance	\$0
<i>What Isn't Covered</i>	
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 plan's overall deductible	\$0
■ Specialist co-payment	\$10
■ Hospital (facility) co-insurance*	\$10
■ Other co-insurance	0%

This EXAMPLE event includes services like:

Emergency room care (<i>including medical supplies</i>)	
Diagnostic tests (<i>X-ray</i>)	
Durable medical equipment (<i>crutches</i>)	
Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$1,900

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Co-payments	\$30
Co-insurance	\$0
<i>What Isn't Covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$30

*Emergency room co-payment

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

Discrimination Is Against the Law

The 1199SEIU Benefit Funds comply with applicable federal civil rights laws and do not discriminate against or exclude people on the basis of race, color, national origin, age, disability or sex. The Funds provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats). The Funds provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Compliance Coordinator. If you believe the Funds have 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: Compliance Coordinator, 330 West 42nd Street, New York, NY 10036; (646) 473-6600 (phone); (646) 473-8959 (fax); PrivacyOfficer@1199Funds.org (email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Coordinator can 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, DC 20201; (800) 368-1019 or (800) 537-7697 (TDD).

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

Language Assistance Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (646) 473-9200.

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 (646) 473-9200。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (646) 473-9200.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (646) 473-9200.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.(646) 473-9200.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (646) 473-9200.

אזקרה מפיא: הליה קארפשי ייא ראפ ואהראפ ונעז, שידיא טדער ריא ביוא: מאזקרה מפיא
טפור -לאצפא ופ יירפ סעסיוורעס (646) 473-9200.

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নথিচায় ভাষা
সহায়তা পরামর্শ উপলব্ধ আছে। ফোন করুন ১ (646) 473-9200.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (646) 473-9200.

رفاوتت ةىوغلللا ةدعاسملا تامدخ نإف، ةغلللا ركذلا ثدحتت تنك اذا: ةظوحلم
مقرب لصتا. ناجملاب كل (646) 473-9200.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (646) 473-9200.

శరద్ధ పోట్టండి: ఒకవోళ మీరు తొలుగు భాష
మాట్లాడుతున్నట్లయితో, మి కొరకు తొలుగు భాషా సహాయక
సేవలు ఉచితంగా లభిస్తాయి. (646) 473-9200.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (646) 473-9200.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (646) 473-9200.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (646) 473-9200.

