PEEHIP: VIVA HEALTH Plan

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Subscriber and Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.whyviva.com/MemberAccess.aspx or by calling 1-800-294-7780.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person / **$900** family; Doesn't apply to preventive care, most drugs or benefits with a **copayment**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services that you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** person / **$150** family for dental coverage. Doesn't apply to preventive care.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. There are no other specific **deductibles**.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,850** person/ **$13,700** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-network expenses for non-emergency and non-urgent services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.myvivaprovider.com or call 1-800-294-7780** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-294-7780 or visit us at www.vivahealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-294-7780 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	Teladoc telehealth service: $40 copay/consult
	Specialist visit	$40 copay/visit	Not covered	----------none----------
	Other practitioner office visit	$40 copay/visit for chiropractor	Not covered	Limited to 25 visits/calendar year.
	Preventive care/ Screening/immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. See plan documents for more information.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance/x-ray; $7.50 copay/test for lab work at independent labs and 10% coinsurance/test for lab work at hospital-based labs	Not covered	Office visit or facility copay may also apply. Covered genetic testing subject to 20% coinsurance. Genetic testing requires prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Imaging (CT/PET scans, MRIs)	$10% coinsurance/test	Not covered	Certain imaging tests require prior authorization for the plan to pay for them. See plan documents for more information. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vivahealth.com	Preferred generic drugs	$5 copay/prescription (retail); $12 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for select generic oral contraceptive drugs.
	Generic drugs	$20 copay/prescription (retail); $43 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). No charge for select generic oral contraceptive drugs.
	Preferred brand drugs	$60 copay/prescription (retail); $150 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Non-preferred brand drugs	$80 copay/ prescription (retail); $200 copay/ prescription (mail order)	Not covered	Covers up to a 31-day supply (retail); 90-day supply (mail order). If generic is available, you pay the difference between the generic and brand price, plus the copay.
	Specialty drugs	30% coinsurance	Not covered	Requires prior authorization. Call 1-800-803-2523. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible applies to drugs received directly from physician or hospital.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/service at an ambulatory surgical center; 10% coinsurance/ service at an Outpatient Hospital	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Physician/surgeon fees	No charge	Not covered	Requires prior authorization for plan to pay for outpatient surgery. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit	Limited to emergency medical conditions. Follow-up care is not covered. See plan documents for more information.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transportation to a hospital.
	Urgent care	$40 copay/visit	$40 copay/visit	Coverage from non-participating providers is limited to care outside the VIVA HEALTH service area and requires prior authorization or a referral from a participating provider. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/ admission; $50 copay/day (days 2-5 only)	Not covered except for emergency medical condition	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan. Outpatient procedures that result in a member being placed in hospital observation will be covered under the outpatient surgery benefit. Hospital observation stays when no procedure is performed that do not result in an inpatient admission will be covered with a $200 copay.
	Physician/surgeon fee	No charge	Not covered except for emergency medical condition	Requires prior authorization for plan to pay for admission except for emergency medical conditions. If prior authorization is not obtained, no charges for those services will be covered by the plan.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	Not covered	Limited to office visits and certain conditions. See plan documents for more information. Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Mental/Behavioral health inpatient services	$200 copay/ admission; $50 copay/day (days 2-5 only)	Not covered except for emergency medical condition	Limited to hospital inpatient care. Requires authorization for plan to pay for admission. If such authorization is not obtained, no charges for those services will be covered by the plan.
	Substance use disorder outpatient services	$40 copay/visit	Not covered	Limited to certain conditions and treatment methods. See plan documents for more information. Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Substance use disorder inpatient services	$200 copay/admission; $50 copay/day (days 2-5 only)	Not covered except for emergency medical condition	Limited to hospital inpatient care. Requires authorization for plan to pay for admission. If such authorization is not obtained, no charges for those services will be covered by the plan.
If you are pregnant	Prenatal and postnatal care	$40 copay/delivery	Not covered	No coverage for dependent children except for preventive prenatal care. See plan documents for more information. No coverage for surrogate pregnancy.
	Delivery and all inpatient services	$200 copay/admission; $50 copay/day (days 2-5 only)	Not covered	No coverage for dependent children or surrogate pregnancy.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization for plan to pay for care. Limited to 60 visits per calendar year. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Rehabilitation services	20% coinsurance; $200 copay/ admission; $50 copay/day (days 2-5 only)	Not covered	Requires prior authorization for plan to pay for therapy. Limited to 25 total outpatient visits per calendar year for physical, occupational and speech therapy and 60 inpatient days. If prior authorization is not obtained, no charges for those services will be covered by the plan.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Habilitation services	20% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. Limited to diagnosis of autism or autism spectrum disorder and 25 total outpatient visits per calendar year for physical, occupational and speech therapy for rehabilitation and habilitation services combined. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Skilled nursing care	20% coinsurance	Not covered	Requires prior authorization for plan to pay for care. Limited to 100 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Durable medical equipment	20% coinsurance	Not covered	Requires prior authorization for plan to pay for service. If prior authorization is not obtained, no charges for those services will be covered by the plan.
	Hospice service	No charge	Not covered	Requires prior authorization for the plan to pay for hospice. Limited to 180 days per lifetime. If prior authorization is not obtained, no charges for those services will be covered by the plan.
If your child needs dental or eye care	Eye exam	$40 copay/visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury.
	Glasses	Not covered	Not covered	Excluded service.
	Dental check-up	No charge	Not covered	Limited to $500 per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other excluded services and your costs for these services.)

- Chiropractic care
- Dental care (Children and adults)
- Routine eye care (Adult)
- Routine foot care (Diabetics only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-294-7780. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: VIVA HEALTH at 1-800-294-7780 and the Alabama Department of Insurance at 334-241-4141.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,940
- **Patient pays** $600

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$0
Limits or exclusions	$200
Total	**$600**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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NONDISCRIMINATION AND LANGUAGE ACCESSIBILITY NOTICE

Nondiscrimination Notice:

VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. VIVA HEALTH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

VIVA HEALTH:

- 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 VIVA HEALTH'S Civil Rights Coordinator.

If you believe that VIVA HEALTH 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 VIVA HEALTH'S Civil Rights Coordinator:

Address: 417 20th Street North, Suite 1100
Birmingham, AL, 35203
Phone: 1-800-294-7780, (TTY: 711)
Fax: 205-449-7626
Email: VIVACivilRightsCoord@uabmc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, VIVA HEALTH'S Civil Rights Coordinator 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, TDD: 1-800-537-7697

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

Grievance Procedure:

It is the policy of VIVA HEALTH not to discriminate on the basis of race, color, national origin, sex, age or disability. VIVA HEALTH has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of VIVA HEALTH's Civil Rights Coordinator:

Address: 417 20th Street North, Suite 1100
Birmingham, AL, 35203
Phone: 1-800-294-7780, (TTY: 711)
Fax: 205-449-7626
Email: VIVACivilRightsCoord@uabmc.edu

VIVA HEALTH's Civil Right Coordinator has been designated to coordinate the efforts of VIVA HEALTH to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for VIVA HEALTH to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of VIVA HEALTH relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the Chief Administrative Officer within 15 days of receiving the Civil Rights Coordinator's decision. The Chief Administrative Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal and administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is 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, TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

VIVA HEALTH will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

Language Assistance Services:

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).

Traditional Chinese
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 1-800-294-7780 (TTY：711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-294-7780 (TTY: 711)번으로 전화해 주십시오

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-294-7780 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-294-7780 (TTY : 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-294-7780 (TTY: 711).

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-294-7780 (ATS: 711).

Gujarati
ધ્યાન: તમે ગુજરાતી બોલે છે, ભાષા સહાય સેવાઓ વિના મૂલ્યે તમારા માટે ઉપલબ્ધ છે . કૉલ 1-800-294-7780 (TTY : 711) .

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-294-7780 (TTY: 711).

Hindi
ध्यान दें: आप हिंदी बोलते हैं, तो भाषा सहायता सेवाओं के प्रभार से मुक्त आप के लिए उपलब्ध हैं। कॉल 1-800-294-7780 (TTY : 711)।

Laotian
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-294-7780 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-294-7780 (телетайп: 711).

Portugese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-294-7780 (TTY: 711).

Turkish
DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-800-294-7780 (TTY: 711) irtibat numaralarını arayın.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-294-7780（TTY: 711）まで、お電話にてご連絡ください.