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, visit www.vivahealth.com/Group/plans/DMS1 . 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 or call 1-800-294-7780 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600/individual or $1,800/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 deductible?	Yes. Preventive care, most drugs, and benefits with a copayment.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$7,900/individual or $15,800/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 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.
Will you pay less if you use a network provider?	Yes. See www.myvivaprovider.com or call 1-800-294-7780 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 **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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	Not covered	Deductible does not apply. Teladoc telehealth Primary/Urgent Care service: $55/consultation.
	Specialist visit	$60 copay/visit	Not covered	Deductible does not apply. Chiropractic services limited to 25 visits per calendar year. Teladoc telehealth Behavioral Health service: $60/consultation. Medical Nutritionist counseling limited to 6 visits per Calendar Year with a Nutritionist or Registered Dietitian.
	Preventive care/ screening/ immunization	No charge	Not covered	Limited to services recommended by federal preventive guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab work; $10 copay/image for x-rays	Not covered	Office visit or facility copay may also apply. Genetic testing requires prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to x-ray imaging.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Certain imaging tests require prior authorization for 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.

*For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/plans/DMS1.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vivahealth.com	Tier 1 Drugs (preferred generic drugs)	$5 copay/prescription (retail); $12 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic oral contraceptive drugs. Deductible does not apply.
	Tier 2 Drugs (non-preferred generic drugs)	$20 copay/prescription (retail); $43 copay/ prescription (mail order)	Not covered	Covers up to a 30-day supply (retail); 90-day supply (mail order). No charge for generic oral contraceptive drugs. Deductible does not apply.
	Tier 3 Drugs (preferred brand and non-preferred generic drugs)	$60 copay/prescription (retail); $150 copay/ prescription (mail order)	Not covered	Covers up to a 30-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. No charge for generic and select brand oral contraceptive drugs. Deductible does not apply.
	Tier 4 Drugs (non-preferred brand and non-preferred generic drugs)	$80 copay/prescription (retail); $200 copay/ prescription (mail order)	Not covered	Covers up to a 30-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. No charge for generic and select brand oral contraceptive drugs. Deductible does not apply.
	Tier 5 Drugs (specialty drugs and non-preferred drugs)	20% coinsurance	Not covered	Requires prior authorization for plan to pay for drugs. 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 the physician or hospital.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	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	20% coinsurance	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 care	$300 copay/visit	$300 copay/visit	Limited to emergency medical conditions. Follow-up care is not covered. See plan documents for more information. Deductible does not apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transportation to a hospital.

*For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/plans/DMS1.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$40 copay/visit (primary care); $60 copay/visit (urgent care center)	$60 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 or a referral is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered except for emergency medical conditions	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.
	Physician/surgeon fees	20% coinsurance	Not covered except for emergency medical conditions	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay/visit	Not covered	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. Deductible does not apply.
	Inpatient services	20% coinsurance	Not covered except for emergency medical conditions	Requires 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.
If you are pregnant	Office visits	$60 copay	Not covered	No coverage for dependent children except for preventive prenatal care. See plan documents for more information. No coverage for surrogate pregnancy. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC. Deductible does not apply to office visit copay.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
	Home health care	20% coinsurance	Not covered	Requires prior authorization for plan to pay for care. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 60 visits per calendar year.

*For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/plans/DMS1.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 30 total outpatient visits per calendar year for physical, occupational, and speech therapy for rehabilitation and habilitation services combined and 60 inpatient days for rehabilitation.
	Habilitation services	20% coinsurance	Not covered	Requires prior authorization for plan to pay for therapy. If prior authorization is not obtained, no charges for those services will be covered by the plan. For medical diagnoses, limited to 30 total outpatient visits per calendar year for physical, occupational, and speech therapy for rehabilitation and habilitation services combined.
	Skilled nursing care	20% coinsurance	Not covered	Requires prior authorization for plan to pay for care. If prior authorization is not obtained, no charges for those services will be covered by the plan. Limited to 100 days per lifetime.
	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 services	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. Limited to 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$60 copay/visit	Not covered	Limited to one routine visit per calendar year and medically necessary visits for illness or injury. Deductible does not apply.
	Children's glasses	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Excluded service.

*For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/plans/DMS1.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury, or congenital anomaly)
- Dental care (Adult and Child)
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)
- Routine foot care (Diabetics only)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 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 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: VIVA HEALTH at 1-800-294-7780, the Alabama Department of Insurance at 334-241-4141, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-294-7780 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-294-7780 (TTY: 711).

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

*For more information about limitations and exceptions, see the plan or policy document at www.vivahealth.com/Group/plans/DMS1.

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 plan's overall deductible	$600
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$70
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,330**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,980**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other cost-sharing	20%/$300

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

NONDISCRIMINATION AND LANGUAGE ACCESSIBILITY NOTICE

Nondiscrimination Notice:

Discrimination is Against the Law

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 (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). VIVA HEALTH does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

VIVA HEALTH:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact VIVA HEALTH'S Section 1557 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 Section 1557 Coordinator, 417 20th Street North, Suite 1100, Birmingham, AL, 35203, 1-800-294-7780, TTY: 711, VIVACivilRightsCoord@uabmc.edu. You can file a grievance by mail, fax, or email. If you need help filing a grievance, VIVA HEALTH'S Section 1557 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.

Language access, effective communication, reasonable modification, and non-discrimination policies and procedures are available at all VIVA HEALTH offices and at vivahealth.com.

Discrimination Grievance Procedure (under Section 1557 of the Affordable Care Act):

In accordance with Section 1557 of the Affordable Care Act (Section 1557), it is the policy of VIVA HEALTH to not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

This is the grievance procedure for providing prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 and its implementing regulations at 45 C.F.R. Part 92, issued by the U.S. Department of Health and Human Services. Section 1557 and its implementing regulations may be examined at https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities.

Any person who believes that VIVA HEALTH subjected someone to discrimination prohibited by Section 1557 may file a grievance under this procedure.

It is against the law for VIVA HEALTH to intimidate, threaten, coerce, retaliate, or otherwise discriminate against anyone who files a grievance, or participates in the investigation of a grievance for the purpose of interfering with any right or privilege secured by Section 1557. Section 1557 and its implementing regulations may be examined in the office of VIVA HEALTH's Section 1557 Coordinator at 417 20th Street North, Suite 1100, Birmingham, AL, 35203.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- Grievances must be submitted in writing to

  VIVA HEALTH Section 1557 Coordinator
  417 20th Street North, Suite 1100
  Birmingham, AL 35203, or

  (by fax or email): 205-449-7626, or VIVACivilRightsCoord@uabmc.edu

- A grievance should contain the name and contact information of the person filing it as well as the alleged discriminatory action and alleged basis (or bases) of discrimination, the date the grievance was filed, and any other pertinent information.

- When a grievance includes allegations that would violate Section 1557, the Section 1557 Coordinator (or their designee, if applicable) shall investigate the grievance. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the grievance.
- VIVA HEALTH shall inform an individual that they have a right to reasonable modifications in the grievance procedure if they need them.
- The Section 1557 Coordinator must keep confidential the identity of an individual who has filed a grievance under this part except as required by law or to carry out the purposes of this part, including the conduct on any investigation, including to investigate the grievance.
- VIVA HEALTH will issue to the person who filed the grievance a written decision on the grievance no later than 30 days after its filing. The decision shall include the resolution date and a notice to the complainant of their right to pursue further administrative or legal remedies.
- VIVA HEALTH will maintain the files and records relating to such grievances for at least three years from the date VIVA HEALTH resolves the grievance.

The person filing the grievance may appeal the written decision by writing to the Chief Administrative Officer within 15 days of receiving the decision. The Chief Administrative Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

VIVA HEALTH, through the Section 1557 Coordinator, will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided reasonable modifications, appropriate 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 these services in a timely manner and without cost to individuals being served to ensure that individuals have an equal opportunity to participate in the grievance process.

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.

Language Assistance Services:

English (English)
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-294-7780 (TTY: 711) or speak to your provider.

Español (Spanish)
ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-294-7780 (TTY: 711) o hable con su proveedor.

中文 (Traditional Chinese)
注意：如果您說中文 (Chinese)，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-294-7780（TTY：711）或與您的提供者討論。

中文 (Simplified Chinese)
注意：如果您說中文 (Chinese)，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-294-7780（文本电话：711）或咨询您的服务提供商。

한국어 (Korean)
주의: 한국어 (Korean) 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-294-7780(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt (Vietnamese), chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-294-7780 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية)Arabic(، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-294-7780 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch (German) sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-294-7780 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Français (French)
ATTENTION : Si vous parlez Français (French), des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-294-7780 (TTY : 711) ou parlez à votre fournisseur.

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-284-7780 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Tagalog (Tagalog)
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-294-7780 (TTY: 711) o makipag-usap sa iyong provider.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-294-7780 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ລາວ (Lao)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ (Lao), ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-294-7780 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский (Russian), вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-294-7780 (TTY: 711) или обратитесь к своему поставщику услуг.

Português (Portuguese)
ATENÇÃO: Se você fala português (Portuguese), serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-294-7780 (TTY: 711) ou fale com seu provedor.

Türkçe (Turkish)
DİKKAT: Türkçe (Turkish) konuşuyorsanız, ücretsiz dil yardım hizmetleri sizin için mevcuttur. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak mevcuttur. 1-800-294-7780 (TTY: 711) numarasını arayın veya sağlayıcınızla görüşün.

日本語 (Japanese)
注：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-294-7780（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。