**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 http://digital.alight.com/southernco or call 1-888-435-7563. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-877-320-7504 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $100/individual or $300/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 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?** | Yes. $50 per person for prescription drug coverage. There are no other specific deductibles. | 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. |
| **What is the out-of-pocket limit for this plan?** | $1,600 individual/$4,800 family for in-network medical, and in and out-of-network mental health, and substance abuse services. For prescription drug coverage: $5,650 individual/$9,800 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, and health care 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 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. |



(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

| | | |
|---|---|---|
| **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 | $10 copay/visit | Not covered | MD Live telehealth service: $15 copay per consultation. Deductible does not apply. |
| | Specialist visit | $30 copay/visit | Not covered | Deductible does not apply. Medical Nutritionist counseling with a Nutritionist or Registered Dietitian limited to 6 visits per Calendar Year. |
| | 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) | No charge | Not covered | Office visit copay may apply. Precertification required for genetic testing; if not obtained, no charges for those services will be covered by the plan. Deductible does not apply. |
| | Imaging (CT/PET scans, MRIs) | No charge | 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. Deductible does not apply. |

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

| 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 http://digital.alight.com/southernco | Generic drugs | Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 10% coinsurance. Up to 90-Day Supply: $10 copay at CVS Pharmacy or CVS Caremark Mail Service. | Not covered | Coinsurance doubled after first 3 fills if maintenance drugs not filled as a 90-day supply. No charge for FDA-approved contraceptives. |
| | Preferred brand drugs | Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 20% coinsurance. Up to 90-Day Supply: $30 copay at CVS Pharmacy or CVS Caremark Mail Service. | Not covered | If generic alternative available, pay difference between generic and brand name. Coinsurance doubled after first 3 fills if maintenance drugs not filled as 90-day supply. |
| | Non-preferred brand drugs | Up to 31-Day Supply: If the full cost is $5 or less: member pays the full cost; If the full cost is greater than $5: member pays the greater of $5 or 30% coinsurance. Up to 90-Day Supply: $60 copay at CVS Pharmacy or CVS Caremark Mail Service. | Not covered | If generic alternative available, pay difference between generic and brand name. Coinsurance doubled after first 3 fills if maintenance drugs not filled as 90-day supply. |
| | Specialty drugs | Generic: $10 copay; Preferred Brand: $30 copay; Non-Preferred Brand: $60 copay | Not covered | Subject to special requirements and prior authorization for plan to pay for Specialty drugs. Contact Caremark Specialty Pharmacy at 1-800-237-2767 for more information. |

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50 copay/service | Not covered except for emergency medical conditions | 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. Deductible does not apply. |
| | Physician/surgeon fees | No charge | Not covered except for emergency medical conditions | 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 | $200 copay/visit | $200 copay/visit | Limited to emergency medical conditions. Copay waived if admitted to hospital. Follow-up care 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. |
| | Urgent care | $75 copay/visit | $75 copay/visit | Coverage from out-of-network providers is limited to care outside the VIVA HEALTH service area. Deductible does not apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $350 /admission | 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. Deductible does not apply. |
| | Physician/surgeon fees | No charge | 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. Deductible does not apply. |

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

| 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 mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | No charge | 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. Deductible does not apply. |
| | Inpatient services | $100 copay/admission. | $100 copay/admission. | 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. Deductible does not apply. |
| **If you are pregnant** | Office visits | $30 copay/delivery | Not covered | 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. See plan documents for more information. Deductible does not apply. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | $350 copay/admission | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | Limited to 100 visits per person per calendar year. 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. |
| | Rehabilitation services | 20% coinsurance | Not covered | Includes physical, speech, and occupational therapy. 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. |
| | 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. |
| | Skilled nursing care | 20% coinsurance | Not covered | Limited to 120 days per person per calendar year. 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. |

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

| 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) | |
| | 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 | No charge | 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. Deductible does not apply. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Limited to one in-network routine visit/year; other medically necessary visits for illness or injury: $30 copay/visit. Deductible does not apply. |
| | Children's glasses | Not covered | Not covered | Excluded service. |
| | Children's dental check-up | No charge | Not covered | Limited to in-network screenings only. |

## 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
- Cosmetic surgery (except reconstructive surgery necessary to repair a functional disorder from disease, injury or congenital anomaly)
- Dental care (adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Bariatric surgery
- Chiropractic care (limited to 25 visits/year)
- Infertility treatment (Progyny network only; limitations apply)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (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,

*For more information about limitations and exceptions, see the plan or policy document at http://digital.alight.com/southernco.

contact: VIVA HEALTH at 1-800-294-7780 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 1-877-320-7504.
Chinese (中文): 如果需要中文的帮助， ☒☒打☒个号☒ 1-877-320-7504.

*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 http://digital.alight.com/southernco.

## 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** **$100**
- **Specialist copay** **$30**
- **Hospital (facility) copay** **$350**
- **Other cost sharing** **none**

**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** | **$12,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $10 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$470** |

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

- **The plan's overall deductible** **$100**
- **Specialist copay** **$30**
- **Hospital (facility) copay** **$350**
- **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** | **$7,400** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $150 |
| Copayments | $300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$570** |

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

- **The plan's overall deductible** **$100**
- **Specialist copay** **$30**
- **Hospital (facility) copay** **$350**
- **Other coinsurance** **20%**

**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** | **$1,900** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $300 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |

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

# 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.