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 https://www.vivahealth.com/Group/Login/. 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?	$500/individual or $1,500/family (Tiers 1 and 2); $3,000/individual or $6,000/family (Tier 3)	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, benefits with a copayment, and benefits where it is indicated that the deductible does not apply.	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. Inpatient hospital: $500 per admission (Tier 2) and $3,000 per admission (Tier 3). Prescription drugs: $100 brand name drug deductible (Tier 1), $200 brand name drug deductible (Tier 2), and $300 brand name drug deductible (Tier 3). 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?	$5,000/individual or $10,000/family (Tiers 1 and 2); $6,000/individual or $12,000/family (Tier 3)	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.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2 or Tier 3. 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	$30 copay/visit, Tiers 1-3	Not covered	Deductible does not apply. Teladoc telehealth Primary/Urgent Care: $10 /consultation.
	Specialist visit	$45 copay/visit, Tiers 1-3	Not covered	Deductible does not apply. Chiropractic coverage is limited to 25 visits per calendar year. Teladoc telehealth Behavioral Health service: $45/consultation.
	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)	Service fees: No charge (Tier 1), 10% coinsurance (Tier 2), or 30% coinsurance (Tier 3); Physician fees: 10% coinsurance (Tiers 1 & 2) or 30% coinsurance (Tier 3)	Not covered	Office visit or facility copay may apply. Some tests may require prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to service fee on Tier 1 or to physician interpretation fees on Tiers 1 and 2
	Imaging (CT/PET scans, MRIs)	Service fees: No charge(Tier 1), 10% coinsurance (Tier 2), or 30% coinsurance (Tier 3); Physician fees: 10% coinsurance (Tiers 1 & 2) or 30% coinsurance (Tier 3)	Not covered	Office visit or facility copay may apply. Some tests may require prior authorization. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply to service fee on Tier 1 or physician interpretation fees on Tiers 1 and 2.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medone-rx.com	Generic drugs	$8 copay/prescription (Tier 1); $20 copay/prescription (Tier 2); $25 copay/ prescription (Tier 3)	Not covered	Covers up to a 30-day supply (retail) with 90-day pricing available. Mail order not covered. Deductible does not apply.
	Preferred brand drugs	$25 copay/prescription (Tier 1); $45 copay/ prescription (Tier 2); $55 copay/prescription (Tier 3)	Not covered	Covers up to a 30-day supply (retail) with 90-day pricing available. Mail order not covered. No charge for preventive drugs required by the Affordable Care Act. Deductible must be satisfied before copayment applies. Tier 1 Deductible -

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

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)	
				$100; Tier 2 Deductible - $200; Tier 3 Deductible - $300
	Non-preferred brand drugs	$45 copay/prescription (Tier 1); $70 copay/ prescription (Tier 2); $80 copay/prescription (Tier 3)	Not covered	Covers up to a 30-day supply (retail) with 90-day pricing available. Mail order not covered. No charge for preventive drugs required by the Affordable Care Act. Deductible must be satisfied before copayment applies. Tier 1 Deductible - $100; Tier 2 Deductible - $200; Tier 3 Deductible - $300
	Specialty drugs	30% coinsurance (Tiers 1-3)	Not covered	Covers up to a 30-day supply (retail). 90-day supply not covered. Mail order not covered. Requires prior authorization for plan to pay for drugs. If prior authorization is not obtained, no charges for those services will be covered by the plan. Pharmacy deductible does not apply. Overall deductible applies to drugs received directly from a physician or hospital.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/service (Tier 1); 10% coinsurance (Tier 2); 30% coinsurance (Tier 3)	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. Deductible does not apply to Tier 1 facility copayment but must be satisfied before coinsurance applies for Tiers 2 and 3. Outpatient facility services received at The Surgery Center in Oxford, AL (TSC) are subject to 10% coinsurance (deductible does not apply) in addition to the $100 copayment.
	Physician/surgeon fees	10% coinsurance (Tiers 1 and 2); 30% coinsurance (Tier 3)	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. Deductible must be satisfied before coinsurance applies.
If you need immediate medical attention	Emergency room care	$150 facility copay/visit and $50 physician copay/visit (Tiers 1-3)	$150 facility copay/visit and $50 physician 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.

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	$45 copay/visit, Tiers 1-3	$45 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)	No charge (Tier 1); 10% coinsurance plus $500 per admission deductible (Tier 2); 30% coinsurance plus $3,000 per admission deductible (Tier 3)	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 Tier 1 facility services. Hospital deductible must be satisfied before coinsurance applies.
	Physician/surgeon fees	10% coinsurance (Tiers 1 and 2); 30% coinsurance (Tier 3)	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. Hospital deductible must be satisfied before coinsurance applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copay/visit (Tiers 1 - 3)	Not covered	Limited to certain care settings, and conditions. See plan documents for more information. Partial Hospitalization and Intensive Outpatient Program services require prior authorization for plan to pay for admission and are covered at no charge. If prior authorization is not obtained, no charges for those services will be covered by the plan. Deductible does not apply.
	Inpatient services	Facility Services: No charge (Tier 1); 10% coinsurance plus $500 per admission deductible (Tier 2); 30% coinsurance plus $3,000 per admission deductible (Tier 3); Physician Services: 10% coinsurance (Tiers 1 & 2); 30% coinsurance (Tier 3)	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. Deductible does not apply for Tier 1 facility services. Hospital deductible must be satisfied before coinsurance 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 are pregnant	Office visits	$45 copay/delivery (Tiers 1 - 3)	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 to office visit copay. Deductible does not apply for Tier 1 facility services. Hospital deductible must be satisfied before coinsurance applies.
	Childbirth/delivery professional services	10% coinsurance (Tiers 1 and 2); 30% coinsurance (Tier 3)	Not covered	
	Childbirth/delivery facility services	No charge (Tier 1); 10% coinsurance plus $500 per admission deductible (Tier 2); 30% coinsurance plus $3,000 per admission deductible (Tier 3)	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance (Tiers 1 -3)	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. Deductible must be satisfied before coinsurance applies.
	Rehabilitation services	10% coinsurance (Tiers 1 & 2); 30% coinsurance (Tier 3)	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 and 60 inpatient days for rehabilitation. Deductible does not apply.
	Habilitation services	10% coinsurance (Tiers 1 & 2); 30% coinsurance (Tier 3)	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 diagnosis of autism, autism spectrum disorder, or pervasive developmental delay. Deductible does not apply.
	Skilled nursing care	Not available (Tier 1); 10% coinsurance (Tier 2); 30% coinsurance (Tier 3)	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. Deductible must be satisfied before coinsurance applies.
	Durable medical equipment	20% coinsurance (Tiers 1 - 3)	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 must be satisfied before coinsurance 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)	
	Hospice services	Not available (Tier 1); 10% coinsurance (Tier 2); 30% coinsurance (Tier 3)	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 must be satisfied before coinsurance applies.
If your child needs dental or eye care	Children's eye exam	$45 copay/visit (Tier 1 – 3)	Not covered	Limited to 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.

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 and Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and Child)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- 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.

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

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.*

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	$500
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	$500
Copayments	$60
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$720**

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

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other coinsurance	10%
Other deductibles	$100

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	$800
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,490**

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

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other cost sharing	10%/$200

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	$500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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.