### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$700 Individual / $1,400 Family Unit in-Network $6,000 Individual / $12,000 Family Unit Out-of-Network</td>
<td>Generally, you must pay all of the costs from providers up to the <strong>deductible</strong> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and some primary care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your <strong>deductible</strong>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $1,400 Individual / $2,800 Family Unit; for out-of-network providers $14,700 Individual / $29,400 Family Unit</td>
<td>The <strong>out-of-pocket limit</strong> 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 <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out–of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.pchp.net">www.pchp.net</a> or call 1-800-400-7247 for a list of network providers.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Piedmont Community HealthCare: Silver 3000/25% CSR87**

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: Individual/Family | Plan Type: HMO-POS

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, call 1-800-400-7247 or visit our website at www.pchp.net. 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.cciio.cms.gov.

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**Important Questions**

1. **What is the overall deductible?**
   - $700 Individual / $1,400 Family Unit in-Network
   - $6,000 Individual / $12,000 Family Unit Out-of-Network

2. **Are there services covered before you meet your deductible?**
   - Yes. Preventive care and some primary care services are covered before you meet your deductible.

3. **Are there other deductibles for specific services?**
   - No

4. **What is the out-of-pocket limit for this plan?**
   - For network providers: $1,400 Individual / $2,800 Family Unit; for out-of-network providers: $14,700 Individual / $29,400 Family Unit

5. **What is not included in the out-of-pocket limit?**
   - Premiums, balance-billing charges, and health care this plan doesn’t cover.

6. **Will you pay less if you use a network provider?**
   - Yes. See www.pchp.net or call 1-800-400-7247 for a list of network providers.

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**Coverage Period:** 01/01/2018 – 12/31/2018

**Coverage for:** Individual/Family | **Plan Type:** HMO-POS

**Silver 3000/25% CSR87**

- **Piedmont Community HealthCare:** Silver 3000/25% CSR87

- **Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

- **Coverage Period:** 01/01/2018 – 12/31/2018

- **Coverage for:** Individual/Family | **Plan Type:** HMO-POS

**Important Questions**

1. **What is the overall deductible?**
   - $700 Individual / $1,400 Family Unit in-Network
   - $6,000 Individual / $12,000 Family Unit Out-of-Network

2. **Are there services covered before you meet your deductible?**
   - Yes. Preventive care and some primary care services are covered before you meet your deductible.

3. **Are there other deductibles for specific services?**
   - No

4. **What is the out-of-pocket limit for this plan?**
   - For network providers: $1,400 Individual / $2,800 Family Unit; for out-of-network providers: $14,700 Individual / $29,400 Family Unit

5. **What is not included in the out-of-pocket limit?**
   - Premiums, balance-billing charges, and health care this plan doesn’t cover.

6. **Will you pay less if you use a network provider?**
   - Yes. See www.pchp.net or call 1-800-400-7247 for a list of network providers.

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**ORC Control Numbers 1545-2229, 1210-0147, and 0938-1146**

**Released on April 6, 2016**
Do you need a referral to see a specialist?  
No. To see a **specialist**, you don’t need a referral from this plan.

You can see a **specialist** you choose without getting permission from this **plan**.

⚠️ **All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay with deductible waived visits 1-3; then 25% coinsurance for other outpatient services; deductible only applies to coinsurance, not to copay</td>
<td>40% coinsurance</td>
<td>[none]</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/Immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>[none]</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1) (Deductible does not apply)</td>
<td>$10 copay/retail $25 copay/mail order</td>
<td>$10 copay/retail $25 copay/mail order See Limitations</td>
<td>Copays are per prescription. Covers up to a 30-day or 100 unit supply (retail prescription); Covers up to a 90-day or 300 unit supply (mail order prescription). This plan requires “mandatory” generic substitution if the FDA has determined the generic to be equivalent to the brand product, unless an In-Network provider requires brand name drugs. Prescriptions filled at an Out-of-Network pharmacy reimbursed up</td>
</tr>
<tr>
<td>Preferred brand drugs (Tier 2) (Deductible does not apply)</td>
<td>$35 copay/retail $87.50 copay/mail order</td>
<td>$35 copay/retail $87.50 copay/mail order See Limitations</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (Tier 3) (Deductible Applies)</td>
<td>50% coinsurance (retail)</td>
<td>50% coinsurance (retail)</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% coinsurance (mail order)</td>
<td>50% coinsurance (mail order) See Limitations</td>
<td>[none]</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>to the amount that would have been paid to an In-Network pharmacy (less copay, deductible and/or coinsurance).</td>
</tr>
<tr>
<td>Specialty drugs, Preferred (Tier 4) (Deductible Applies)</td>
<td>Specialty drugs, Non-Preferred (Tier 5) (Deductible Applies)</td>
<td>50% coinsurance (retail) 50% coinsurance (mail order)</td>
<td>50% coinsurance (retail) 50% coinsurance (mail order)</td>
<td>Preauthorization is required. If you don’t get preauthorization, benefits could be covered as Out-of-Network.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don’t get preauthorization, benefits could be covered as Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
<td>If not an actual emergency, covered at 50% coinsurance after deductible.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don’t get preauthorization, benefits could be covered as Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 copay with deductible waived visits 1-3; then 25% coinsurance for other outpatient services</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for any inpatient or outpatient facility services. Pre-authorization required for any services and office visits from Out-of-Network providers. Covered as Out-of-Network without pre-authorization.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 100 visits/calendar year</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Physical/Occupational therapy or Speech therapy limited to 30 visits/yr each for rehabilitative or habilitative services.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 100 visits/calendar year</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for costs in excess of $750.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 60% of the total cost of the service.</td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>40% coinsurance</td>
<td>Limited to one routine eye exam per year for Participants up to age 19.</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>No Charge with limitations</td>
<td>40% coinsurance</td>
<td>Limited to one pair of standard glasses (lenses and frames), or one pair of contact lenses per year from a limited collection.</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Dental check-up is Not Covered.</td>
<td></td>
</tr>
</tbody>
</table>

**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.**)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult) (except for accidental injury)
- Glasses (except for pediatric vision benefits)
- Hearing aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care (unless you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
- 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 (total spinal manipulation / chiropractic services limited to 30 visits each per year for rehabilitative or habilitative services)
- Habilitation services
- Private-duty nursing (limited to 16 hours per year)

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**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: contact the plan at 1-800-400-7247. 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/ebsha/consumerassistance.html](http://www.dol.gov/ebsha/consumerassistance.html), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.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](http://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: Piedmont at 1-800-400-7247 (434-947-4463 if local), or visit [www.pchp.net](http://www.pchp.net). You may also contact the U.S. Department of Labor at 1-866-444-3272 or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or call the Virginia Bureau of Insurance at 1-877-310-6560 or visit [www.scc.virginia.gov/boi/omb](http://www.scc.virginia.gov/boi/omb). Additionally, a consumer assistance program can help you file your appeal. Contact the Virginia Bureau of Insurance, Office of Managed Care Ombudsman at 1-877-310-6560 or , [www.scc.virginia.gov/boi/omb](http://www.scc.virginia.gov/boi/omb), or for assistance with complaints regarding the quality of health care services received, contact the Virginia Department of Health, Office of Licensure at 1-800-955-1819 or [www.vdh.state.va.us/OLC/Complaint](http://www.vdh.state.va.us/OLC/Complaint).

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards?** Yes.

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

**English** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

**Espanol** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 1-877-295-1454).


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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: $700
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$700</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$700</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay: **$1,460**

### Managing Joe’s type 2 Diabetes

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

- The plan’s overall deductible: $700
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$700</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Joe would pay: **$1,460**

### Mia’s Simple Fracture

(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $700
- Specialist copayment: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 25%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$700</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay: **$1,000**

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**Note:** These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-400-7247 or visit us at [www.pchp.net](http://www.pchp.net).

**Note:** 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 Notice

Piedmont Community Health Plan, on behalf of itself and its affiliates (hereafter “Piedmont”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Piedmont does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Piedmont:

- 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 Customer Service at 1-800-400-7247 (TTY: 711)

If you believe that Piedmont 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 our Compliance Officer by mail or phone:

Compliance Officer
Piedmont Community Health Plan
2316 Atherholt Road
Lynchburg, VA 24501
434-947-4463 (TTY: 711)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-400-7247 (TTY: 711).

ATENCIÓN: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-400-7247 (ATS: 711).


警告: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 1-800-400-7247（TTY: 711）

Предупреждение: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-400-7247 (телефон для слепых: 711).

警告:如果您使用簡體中文, 您可以利用免費語言援助服務。請致電 1-800-400-7247 (TTY: 711)

Nota: Si parla italiano, è disponibile un servizio di assistenza linguistica, gratuito, a disposizione. Chiamare il numero 1 800 400 7247 (TTY: 711).

가요: 언어이 모두 러시아어로, 간편한 언어 지원 서비스가 제공됩니다. 1 800 400 7247 (TTY: 711)에 전화해 주세요.

العربية: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل بقم 7247-400-1-800 (رقم هاتف الصم والبكم: 711).

گفتگو: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما قرآه می باشد. با (رقم هاتف الصم والبكم: 711) 1 800 400 7247 تماس بگیرید.

超流注意: 您可以使用免费的语言援助服务。请致电 1 800 400 7247 (TTY: 711)。

注意:如果您使用简体中文, 您可以免费获得语言援助服务。请致电 1-800-400-7247 (TTY: 711)。