



State of Alabama (13000)

Coverage For: Individual + Family Plan Type: PPO



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 1-800-824-0435 or visit us at AlabamaBlue.com. 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.bcbsal.org/sbcglossary/ or call 1-800-824-0435 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$300 per person per calendar year Maximum of three deductibles per 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 up to a maximum of three deductibles per family .
Are there services covered before you meet your deductible ?	Yes. Preventive services in-network are covered before you meet your deductible .	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. \$250 per inpatient facility deductible; \$250 outpatient facility deductible. There are 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 ?	\$9,200 individual/\$18,400 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 limit 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, cost sharing for most out-of-network benefits, pre-certification penalties and payments made by drug manufacturer assistance programs.	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 AlabamaBlue.com or call 1-800-810-BLUE 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	\$35 copay /visit Annual deductible does not apply	20% coinsurance Annual deductible applies	Subject to \$35 in-network copay for nurse practitioner, nurse midwife, or physician's assistant; includes office surgery and consultations; precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available Please visit AlabamaBlue.com/PreventiveServices ; additional services are available. 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
	Specialist visit	\$35 copay /visit Annual deductible does not apply	20% coinsurance Annual deductible applies	
	Preventive care/screening/immunization	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	
If you have a test	Diagnostic test (x-ray, blood work)	\$7.50 copay per lab test Annual deductible does not apply	20% coinsurance Annual deductible applies	Benefits listed are physician services ; subject to overall deductible for out-of-network; facility benefits are also available; lab/pathology copay may apply; precertification may be required for coverage; if no precertification is obtained, no benefits are available †Limited to 2 copays per date of service for each of the following: Angiography/arteriography, cardiac cath/arteriography, colonoscopy, UGI endoscopy, CAT Scan, MRI, MUGA-Gated Cardia Scan, ERCP, PET/PECT and Thallium Scan
	Imaging (CT/PET scans, MRIs)	\$75 copay per test† Annual deductible does not apply	20% coinsurance Annual 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)	
<p>If you need drugs to treat your illness or condition</p> <p>Administered by Prime Therapeutics</p> <p>More information about prescription drug coverage is available at www.myprime.com</p> <p>Note: Copays are based on a 30-day supply</p>	Tier 1 Drugs	\$10 copay (retail) ⁺ Annual deductible does not apply	Not Covered	<p>Precertification is required for specific drugs; if no precertification is obtained, no benefits are available; when you get a prescription for a brand name drug that has a Tier 1 generic equivalent, you must first try the generic equivalent drug for your prescription to be covered by your prescription drug program. If you choose to get the brand name drug without trying the generic equivalent first, there will be no coverage for the brand name drug.</p> <ul style="list-style-type: none"> Tier 1 drugs - \$10 copay per prescription limited to 30 or 60 day supply; ⁺subject to \$20 copay per prescription for 90-day supply; if the drug is over \$50, the member will pay the Tier 2 copay; Tier 2 drugs - limited to a 30, 60 or 90-day supply; Tier 3 - limited to 30-day supply; Tier 4 - limited to a 30-day supply; Tier 5 - limited to a 30-day supply; <p>⁺⁺Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs</p>
	Tier 2 Drugs	20% coinsurance (retail) with a minimum copay of \$45 and a maximum copay of \$85 per prescription Annual deductible does not apply	Not Covered	
	Tier 3 Drugs	50% coinsurance (retail) with a minimum copay of \$65 and a maximum copay of \$125 per prescription Annual deductible does not apply	Not Covered	
	Tier 4 Drugs	50% coinsurance (retail) with a maximum copay of \$150 per prescription Annual deductible does not apply	Not Covered	
	Tier 5 Drugs (preferred specialty)	\$150 copay (retail) per prescription ⁺⁺ Annual deductible does not apply	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	\$250 copay Annual deductible does not apply	20% coinsurance Annual deductible applies	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	Copay applies for surgery rendered at an in-network physician's office

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 immediate medical attention	Emergency room care	Accident: No Charge Annual deductible does not apply Medical Emergency: \$250 copay /visit Annual deductible does not apply	Accident: No Charge Annual deductible does not apply Medical Emergency: \$250 copay /visit Annual deductible does not apply	Physician charges will apply
	Emergency medical transportation	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Ground Ambulance: If the provider is out of network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Urgent care	\$75 copay /visit Annual deductible does not apply	20% coinsurance Annual deductible applies	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 per admission deductible & \$25 copay /day days 2-5 Annual deductible does not apply	\$250 per admission deductible & 20% coinsurance Annual deductible does not apply	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	None

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	\$35 copay /visit Annual deductible does not apply	20% coinsurance Annual deductible applies	Precertification is required for intensive outpatient and partial hospitalization ; if no precertification is obtained, no benefits are available; benefits are available for Applied Behavioral Analysis (ABA) therapy (precertification required); residential treatment facility benefits are available limited to eating disorder treatment (precertification required)
	Inpatient services	Inpatient Facility: \$250 per admission deductible & \$25 copay /day days 2-5 Annual deductible does not apply Physician services: No Charge Annual deductible does not apply	Inpatient Facility: \$250 per admission deductible & 20% coinsurance Annual deductible does not apply Physician services: 20% coinsurance Annual deductible does not apply	
If you are pregnant	Office visits	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); facility deductible and daily copay waived if the female employee or female spouse of an employee enrolls in the Baby Yourself Program within the first two trimesters precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available
	Childbirth/delivery professional services	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	
	Childbirth/delivery facility services	\$250 per admission deductible & \$25 copay /day days 2-5 Annual deductible does not apply	\$250 per admission deductible & 20% coinsurance Annual deductible does not apply	

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	Home health care	20% coinsurance Annual deductible applies	Not Covered	In Alabama, out-of-network not covered; benefits are also available for home infusion services; precertification is required; if no precertification is obtained, no benefits are available
	Rehabilitation and Habilitation physical, speech, and occupational therapy	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Each service is limited to 15 visits per therapy per member per calendar year; Precertification is required after the 15th visit to determine the medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied; precertification is not required for home visits; for out-of-network, member is responsible for the 20% coinsurance and any amount billed over the fee schedule
	Skilled nursing care	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	Precertification is required; if no precertification is obtained, no benefits are available; benefits only available if approved through case management
	Durable medical equipment	20% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	If the provider is out of network, the member is responsible for the 20% coinsurance and any amount billed over the fee schedule; precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	20% coinsurance Annual deductible applies	Not Covered	In Alabama, out-of-network not covered; precertification is required; if no precertification is obtained, no benefits are available; benefits only available if approved through case management

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)	
	Applied Behavioral Analysis (ABA) Therapy	\$35 copay /visit Annual deductible does not apply	20% coinsurance Annual deductible applies	<u>Preauthorization</u> is required prior to rendering ABA therapy to determine the medical necessity. <u>Preauthorization</u> is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied; benefits listed are for children 18 years or younger
If your child needs dental or eye care	Children's eye exam	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	Please visit AlabamaBlue.com/PreventiveServices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	No Charge Annual deductible does not apply	20% coinsurance Annual deductible applies	Please visit AlabamaBlue.com/PreventiveServices

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 .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Glasses, child• Hearing aids• Long-term care	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Bariatric surgery (only morbid obesity in limited circumstances)• Chiropractic care (precertification is required after the 18th visit)	<ul style="list-style-type: none">• Infertility treatment (Assisted Reproductive Technology not covered)• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private-duty nursing (precertification is required for coverage)• Maternity Management (Baby Yourself Program)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or your [plan](#) administrator at the phone number listed in your benefit booklet. 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 on how 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: Blue Cross and Blue Shield of Alabama at 1-800-824-0435

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 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](#).

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$300	■ The plan's overall deductible	\$300	■ The plan's overall deductible	\$300
■ Specialist copayment	\$35	■ Specialist copayment	\$35	■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$25	■ Hospital (facility) copayment	\$25	■ Hospital (facility) copayment	\$25
■ Other copayment/coinsurance	\$35/20%	■ Other copayment/coinsurance	\$35/20%	■ Other copay/coinsurance	\$35/20%
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$200	Deductibles	\$300
Copayments	\$400	Copayments	\$500	Copayments	\$100
Coinsurance	\$0	Coinsurance	\$100	Coinsurance	\$300
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$40	Limits or exclusions	\$0
The total Peg would pay is	\$460	The total Joe would pay is	\$840	The total Mia would pay is	\$700

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: [AlabamaBlue.com](#).

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

Language Assistance Services, Auxiliary Aids, Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have 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 in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance 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, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: 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 1-855-216-3144 (TTY: 711) or call Customer Service.

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات 1-855-216-3144 والاتصال بالرقم 711 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا.

Chinese: 请注意: 如果您说普通话, 我们可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, 以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુવલ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કોલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese: ご案内: 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເຄົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.