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BlueCard® PPO
Plan Benefits

The University of Alabama at Huntsville
79912
BlueCard® PPO

Effective January 01, 2021

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An Independent Licensee of the Blue Cross and Blue Shield Association

The University of Alabama at Huntsville
BlueCard® PPO
Effective January 01, 2021

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar Year Medical Deductible	$150 per individual per calendar year	
Calendar Year Pharmacy Deductible	$150 per individual per calendar year	
Calendar Year Out-of-Pocket Maximum	$2,500 individual; $7,150 family **In-network:** All copays, deductibles and coinsurance including copay for out-of-network mental health and substance abuse ER and ER physician services will apply to the in-network out-of-pocket maximum excluding prescription drugs; available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum. There is a separate $2,500 individual; $7,150 family prescription drug out-of-pocket maximum After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for the remainder of the calendar year **Out-of-network:** All copays and coinsurance for out-of-network other covered services apply to the annual out-of-pocket maximum In-network and out-of-network out-of-pocket amounts apply to each other	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and maternity); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll-free) for precertification.		
Inpatient Hospital and Residential Treatment Facilities	Covered at 100% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to $400.00 per admission copay and subject to calendar year deductible; 365 days per confinement.	Covered at 80% of the allowed amount for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries, subject to $400.00 per admission copay and subject to calendar year deductible; 365 days per confinement. **Note:** In Alabama, available only for medical emergency and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** apply to the in-network out-of-pocket maximum

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Non-Emergency	Covered at 80% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible
Emergency Room (Accident)	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to $150.00 hospital copay and subject to calendar year deductible
Emergency Room (Physician)	Covered at 100% of the allowed amount, subject to $55.00 physician copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to $55.00 physician copay and subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** apply to the in-network out-of-pocket maximum
Chemotherapy, Hemodialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to $125.00 copay and subject to calendar year deductible **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.	Covered at 80% of the allowed amount, subject to calendar year deductible MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 80% of the allowed amount, subject to $125.00 copay and subject to calendar year deductible **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 100% of the allowed amount, subject to $55.00 daily hospital copay and subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits and provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and Outpatient Consultations Rendered by a Primary Care Physician (Includes: Internist, Family & General Practitioner, Pediatrician, OB/GYN & Geriatrician)	Covered at 100% of the allowed amount, subject to $35.00 physician copay and subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Office Visits and In-Person Consultations Rendered by a Specialist	Covered at 100% of the allowed amount, subject to $55.00 physician copay and subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Nurse Practitioner/Nurse Midwife/Clinical Nurse Specialist/Mental Health Nurse Practitioner/Mental Health Clinical Nurse Specialist and Physician Assistant's Office Visits and Consultations	Covered at 100% of the allowed amount, subject to $20.00 physician copay and subject to calendar year deductible Services must be rendered under the supervision of a PPO doctor.	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to **Teladoc.com/Alabama** or call 1-855-477-4549	Covered at 100% of the allowed amount, subject to $20.00 payment per consultation	Not Covered
Surgery Performed in a Physician's Office	Covered at 100% of the allowed amount, subject to $35.00 office visit copay and subject to calendar year deductible if performed by a Primary Care Physician Covered at 100% of the allowed amount subject to $55.00 office visit copay and subject to calendar year deductible if performed by a Specialist	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible
Hemodialysis, Chemotherapy, Radiation Therapy & IV Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Outside Alabama**, Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Lab & X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 100% of the allowed amount, subject to a $35.00 copay and subject to calendar year deductible. **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible. However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 50% of the allowed amount, subject to a $35.00 copay and subject to calendar year deductible **Outside Alabama**, covered at 80% of the allowed amount, subject to calendar year deductible. However MRI(s), CAT, PET & Thallium Scans, Cardiac Scans, heart catheterizations, colonoscopy and endoscopy covered at 80% of the allowed amount, subject to a $35.00 copay and subject to calendar year deductible **Note**: If there is more than one procedure done on the same date of service there will be **only** one copayment taken for the facility and **only** one copayment taken for the physician.
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorder. Ages 0-9 limited to an annual maximum of $20,000, ages 10-13 limited to an annual maximum of $15,000 and ages 14-18 limited to an annual maximum of $10,000.	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
PREVENTIVE CARE BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/ NetResultsACAPreventiveDrugList** for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Retail Prescription Drug Card Benefits • The pharmacy network for the plan is **Prime Participating Network** • Some copays combined for diabetic supplies • Fertility medications are covered • Prescription drugs - up to a 31-Day supply • The only in-network pharmacy for someTier 4 (specialty) drugs is the **Pharmacy Select Network**; view the Specialty Drug Lists at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** • View the **NetResults 1.0 (Up to 4 Tier)** drug lists that apply to the plan at **AlabamaBlue.com/NetResults1 DrugList4T** • Certain specialty drugs are listed on the Specialty Drug Coupon Program List at **AlabamaBlue.com/ specialtycouponprogramdruglist** • Locate a **Prime Participating Network** pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator**	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 drugs subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $45 copay per prescription **Tier 3 Drugs:** $65 copay per prescription **Tier 4 (specialty) Drugs:** $125 copay per prescription Drugs on the Specialty Drug Coupon Program List must be purchased at a pharmacy in the Select Pharmacy network and are subject to the greater of the applicable Tier copay or the full amount of the available manufacturer cost share assistance program payments. **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Not Covered
Extended Supply Prescription Drug Card Benefits • The extended supply pharmacy network for the plan is the **Prime Participating Network ESN Network** • Prescription drugs-up to 31 day supply • Maintenance only-up to 90 days with two copays • Tier 4 (specialty) drugs are not available through extended supply pharmacy service • View the **NetResults 1.0 (Up to 4 Tier)** and maintenance drug lists that apply to the plan at **AlabamaBlue.com/AlabamaBlue. com/NetResults1DrugList4T** • Locate a **Prime Participating Network ESN Network** pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator**	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $45 copay per prescription **Tier 3 Drugs:** $65 copay per prescription **Tier 4 (specialty) Drugs:** Not Covered **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mail Order Pharmacy Benefits • Prescription drugs-up to 31 day supply • Maintenance only-up to 90 days with two copays • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com** or call 1-800-391-1886) • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/Maintenance DrugList** • View the NetResults 1.0 (Up to 4 Tier) drug lists that apply to the plan at **AlabamaBlue.com/NetResults 1DrugList4T**	Covered at 100% of the allowed amount, Tier 2, Tier 3 and Tier 4 subject to separate $150 prescription drug deductible per person per calendar year. **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $35 copay per prescription **Tier 3 Drugs:** $55 copay per prescription **Tier 4 (specialty) Drugs:** Not covered **Separate Annual Out-of-Pocket Maximum:** $2,500 per person $7,150 per family If Generic drug is available and Tier 3 (Non Preferred) Brand drug is selected, member will be responsible for the difference in price plus the applicable Tier 3 (Non Preferred) brand copay	Not Covered
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse) **Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.**		
Allergy Testing & Treatment	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to a maximum of 24 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible when services are provided by a participating in network chiropractor	**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible when services are provided by a non-Participating Chiropractor **Outside Alabama,** covered at 80% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational and Speech Therapy Occupational and speech therapy limited to a maximum of 30 visits per person per therapy each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Habilitative Occupational and Speech Therapy Occupational and speech therapy limited to a maximum of 30 visits per person per therapy each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Rehabilitative Physical Therapy Limited to a maximum of 30 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Habilitative Physical Therapy Limited to a maximum of 30 visits per person each calendar year	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Occupational and Speech Therapy for Autism Diagnosis ages 0-18	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Nutritionist Visits Limited to a maximum of eight visits per person each calendar year. Note: Employee is also responsible for any charges above the allowance.	Covered at 100% of the allowed amount, subject to $20.00 physician copay and subject to calendar year deductible	Covered at 100% of the allowed amount, subject to $20.00 physician copay and subject to calendar year deductible
Preferred Home Health and Hospice	Covered at 100% of the allowed amount, subject to calendar year deductible	**In Alabama,** no benefits available if a non-preferred provider is used **Outside Alabama**, covered at 80% of the allowed amount, subject to calendar year deductible Precertification is required for services rendered outside Alabama. Call 1-800-821-7231
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease and other specialized conditions.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself.**	
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
Air Medical Transport	Air medical transportation to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	
Quit for Life Tobacco Cessation Program	A tobacco cessation program for *subscriber, spouse and dependents* that provides support to participants through telephone-based counseling and nicotine replacement therapy. Call 1-888-768-7848 for participation information.	
Naturally Slim ®	Naturally Slim® is an online clinical behavioral weight loss program.	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website* ***(AlabamaBlue.com)*** *or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*
- *Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical services does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan. Air medical transport services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical services terminate if coverage by your health plan ends.*
- *Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.*

This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet). Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.

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. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free 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 services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these 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.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

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1-855-216-3144（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل بالرقم 1-855-216-3144 (رقم هاتف الصم والبكم: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche leistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગજરાતી બોલતા હો, તો ભાષા સહાયતા સેવા, તમારા માટે નઃશલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

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。
1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。