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BlueCard® PPO Plan Benefits

City of Birmingham-Premier Medical Plan

BlueCard® PPO

Effective July 1, 2025

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

City of Birmingham-Premier Medical Plan
BlueCard® PPO
Effective July 1, 2025

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		
Plan year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Plan Year Deductible July 01, 2025 – June 30, 2026	$1,500 individual; $3,000 family	
Plan Year Out-of-Pocket Maximum July 01, 2025 – June 30, 2026	$4,000 individual; $8,000 family All deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, excluding prescription drugs. Coinsurance for out-of-network Home Health, Hospice, and Other Covered Services (excluding durable medical equipment) applies to the out-of-pocket maximum. Payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. After you reach Plan Year Out-of-Pocket Maximum, applicable expenses covered at 100% for remainder of plan year.	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal Law); 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	Covered at 100% of the allowed amount, after $250.00 hospital copay per admission	Covered at 50% of the allowed amount, subject to $1,500.00 per admission deductible **Note:** In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% of the allowed amount with no deductible or copay	Covered at 50% of the allowed amount subject to the plan year deductible.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for some outpatient hospital benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after $100.00 hospital copay	Covered at 50% of the allowed amount, subject to plan year deductible **In Alabama**, not covered
Emergency Room (Medical Emergency and Accidental Injury) Copay waived if admitted Maximums are combined for in and out-of-network	Covered at 100% of the allowed amount, after $200.00 hospital copay for the first two visits, 100% after $300.00 copay for additional visits	Covered at 100% of the allowed amount, after $200.00 hospital copay for the first two visits, 100% after $300.00 copay for additional visits
Emergency Room (Physician)	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Chemotherapy, IV Therapy, Outpatient Diagnostic Lab, Pathology and Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Dialysis	**Dialysis Center Inc. (DCI**): Covered at 100% of the allowed amount, subject to plan year deductible **Other than DCI**: Covered at 70% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Imaging	Covered at 100% of the allowed amount, after $50.00 hospital copay	Covered at 50% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS		
Precertification is required for some physician benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits and Consultations-Primary Care Physician	Covered at 100% of the allowed amount, after $25.00 physician copay	Covered at 50% of the allowed amount, subject to plan year deductible
Office Visits and Consultations-Specialist	Covered at 100% of the allowed amount, after $40.00 physician copay	Covered at 50% of the allowed amount, subject to plan year deductible
Diagnostic Imaging (in the physician's office)	Covered at 100% of the allowed amount, after $50.00 copay. Office visit copay also applies	Covered at 50% of the allowed amount, subject to plan year deductible
Urgent Care	Covered at 100% of the allowed amount, after $50.00 physician copay	Covered at 50% of the allowed amount, subject to plan year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Maternity Care (Pre/Postnatal care and Delivery) Midwives are eligible providers	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology and Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/NetResultsACAPreventiveDrugList** for a listing of 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; **In addition to the standard, the following exceptions apply:** • Urinalysis and CBC (when necessary) • TB skin testing (when necessary) • Lipid Panel (when necessary) • Comprehensive Metabolic Panel (when necessary) • Venipuncture (when necessary) • Chromosome testing (when necessary)	Not Covered **Exception:** Routine pap smear (one per member per year), routine human papillomavirus (HPV) testing (one per member every three years age 30 and over) and routine chlamydia screening (ages 15-99) covered at 50% of the allowed amount subject to the plan year deductible.
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		
Precertification is required for some drugs; if no precertification is obtained, no benefits are available.		
Retail Prescription Prepaid Benefits • Up to 30-day supply at retail for non-maintenance drugs • Up to a 90-day supply at retail for maintenance drugs for two grace fills (mandatory mail order or extended supply network for maintenance drugs after two grace fills at retail or member will be responsible for 100% of prescription drug) • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** • Some copays combined for diabetic supplies • The pharmacy network for the plan is the **Prime Participating Network** • Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Specialty drugs is the **Pharmacy Select Network**; visit **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** for a list of these specialty drugs • View the **NetResults 1.0** drug list that applies to the plan at **AlabamaBlue.com/NetResults1DrugList4T** • Locate a Prime Participating Network pharmacy at **AlabamaBlue.com/PrimeParticipatingPharmacyLocator** • Certain drugs are part of the FlexAccess Program. See list at **AlabamaBlue.com/FlexAccessDrugList** • **Note**: Prescription drugs have a separate out-of-pocket from medical: **$1,600 individual/$3,200 family**	Covered at 100% of the allowed amount, subject to the following copays: **Tier 1:** $7 copay per prescription (30-day supply) **Tier 2:** $40 copay per prescription (30-day supply) **Tier 3:** $60 copay per prescription (30-day supply) **Tier 4 (Specialty Drugs):** $70 copay per prescription (30-day supply) **Weight Loss Medications** (covered at retail only up to a 30-day supply): Covered at 80% of the allowed amount, subject to plan year deductible. For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program.	Not Covered
Extended Supply Prescription Prepaid Benefits • Up to 90-day supply • The extended supply pharmacy network for the plan is the **Prime Participating Network** • Locate a Prime Participating Network pharmacy at **AlabamaBlue.com/PrimeParticipatingPharmacyLocator** • Maintenance drugs only can be purchased through this extended supply pharmacy service up to a 90-day supply with one copay • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** • View the **NetResults 1.0** drug list that applies to the plan at **AlabamaBlue.com/NetResults1DrugList4T** • Tier 4 (specialty) drugs are not available through this extended supply pharmacy service • **Note**: Prescription drugs have a separate out-of-pocket from medical: **$1,600 individual/$3,200 family**	Covered at 100% of the allowed amount, subject to the following copays: **Tier 1:** $12 copay per prescription (31-90 day supply) **Tier 2**: $45 copay per prescription (31-90 day supply) **Tier 3:** $75 copay per prescription (31-90 day supply) **Tier 4 (Specialty Drugs):** Covered under retail pharmacy benefit at 30-day supply (not covered as an extended supply)-see retail section above for specialty drugs	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Select Generic Specialty and Biosimilar drugs • Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. • The only in-network pharmacy for some generic specialty and biosimilar drugs is the **Pharmacy Select Network.** • View the **Select Generic Specialty** and Biosimilar Drug List that applies to the plan at **AlabamaBlue.com/Select Generic SpecialtyandBiosimilarDrugList**. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	Covered at 100% of the allowed amount, no deductible or copay	Not Covered
Mail Order Pharmacy Benefits • Up to 90-day supply available for maintenance drugs with one copay • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** • Mail order drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/HomeDeliveryNetwork** or call 1-855-793-5326 or call Express Scripts at 1-833-721-1628) • View the **NetResults 1.0** drug list that applies to the plan at **AlabamaBlue.com/NetResults1DrugList4T** • **Note**: Prescription drugs have a separate out-of-pocket from medical: **$1,600 individual/$3,200 family** **Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order program	Covered at 100% of the allowed amount subject to the following copays: **Tier 1:** $10 copay per prescription **Tier 2:** $40 copay per prescription **Tier 3:** $65 copay per prescription **Tier 4 (Specialty Drugs):** See retail section above for specialty drugs	Not Covered
VISION BENEFITS		
Routine Vision • Limited to one routine eye exam per person per plan year • Benefit are provided for orthoptic eye muscle exercise limited to 30 visits per member per lifetime	Covered at 100% of the allowed amount, no copay or deductible	**Routine Vision:** Covered at 100% of the allowed amount, no copay or deductible **Orthoptic Eye Muscle Exercise:** Covered at 80% of the allowed amount, subject to plan year deductible
BENEFITS FOR OTHER COVERED SERVICES		
Precertification is required for some other covered services and provider administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Allergy Testing & Treatment	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Ambulance Service	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Participating Chiropractic Services Limited to 20 visits per person per plan year (in and out-of-network combined)	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME) Precertification required for charges in excess of $1,000.	Covered at 100% of the allowed amount, no copay or deductible for the first $5,000. Thereafter, covered at 80% of the allowed amount with no copay or deductible (in-network and out-of-network combined)	Covered at 100% of the allowed amount, no copay or deductible for the first $5,000. Thereafter, covered at 80% of the allowed amount with no copay or deductible (in-network and out-of-network combined)
Rehabilitative Occupational, Physical and Speech Therapy Limited to 20 visits per therapy per person per plan year (in and out-of-network combined). No visit limit when related to Autism diagnosis	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Habilitative Occupational, Physical and Speech Therapy Limited to 20 visits per therapy per person per plan year (in and out-of-network combined) No visit limit when related to Autism diagnosis	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Preferred Home Health and Hospice Home health limited to a maximum of 60 visits per person per plan year (in and out-of-network combined). Hospice limited to a maximum of 180 days per person per lifetime (in and out-of-network combined).	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Home Infusion Benefits	Covered at 100% of the allowed amount, after $40.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Skilled Nursing Facility Limited to the first 60 days of confinement per person per plan year (in and out-of-network combined).	Covered at 100% of the allowed amount, subject to plan year deductible	Covered at 100% of the allowed amount, subject to plan year deductible
Private Duty Nursing Limited to a lifetime maximum of $50,000 per person.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Organ Transplants National Transplant Network-Services must be coordinated through Managed Care Benefits for travel, lodging and meals are limited to a maximum payment of $50.00 per person up to a maximum payment of $100.00 for two members (recipient and companion) per day with a combined lifetime maximum payment of $10,000.00 per member	**Transplant Surgery:** Covered like any other service for inpatient hospital, inpatient physician, office visits, etc. **Travel and Lodging:** Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Cardiac Rehabilitation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Diabetic Education	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Infertility Testing and Treatment	Covered at 100% of the allowed amount, no copay or deductible; copay applies to the office visit and labs	Covered at 80% of the allowed amount, subject to plan year deductible
Bariatric Surgery Benefits are provided in Alabama **only** when services are rendered by a provider in the Bariatric Network	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Medical Nutrition Therapy For Adults and Children, 6 hours per member per plan year	Covered at 100% of the allowed amount, after $25.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Gender Reassignment Surgery **Note**: You are covered for management, consultation, counseling, hormones, and surgical services for purposes of affirming your gender identity and/or gender transition (diagnostically referred to as gender dysphoria), including related medical visits and laboratory services. Specific benefit criteria (based on the World Professional Association for Transgender Health (WPATH) standards of care guidelines) must be met.	**Inpatient Hospital**: Covered at 100% of the allowed amount, after $250.00 hospital copay per admission **Office Visit**: Covered at 100% of the allowed amount, after $40.00 physician copay **Lab/Pathology:** Covered at 100% of the allowed amount, no copay or deductible **Diagnostic Imaging:** Covered at 100% of the allowed amount, after $50.00 hospital copay Benefits will be provided the same as your benefits for any other condition or covered service	**Inpatient Hospital:** Covered at 50% of the allowed amount, subject to $1,500.00 per admission deductible **Office Visit, Lab/Pathology, Diagnostic Imaging:** Covered at 50% of the allowed amount, subject to plan year deductible Benefits will be provided the same as your benefits for any other condition or covered service
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE		
Mental Health Disorders and Substance Abuse	Mental Health Disorders and Substance Abuse are covered through Behavioral Health Systems. For more information call 1-800-245-1150.	
HEALTH MANAGEMENT BENEFITS		
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.	

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 Pharmacy Benefit Manager(s).*
- *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.*
- *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.*
- *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, the average charge for care in the area or in accordance with applicable Federal Law.*
- *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.*

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

Discrimination is Against the Law

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 والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

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 Sprachassistenzdienste 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 નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ 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 કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क 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: 한국어을(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: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. 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.