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BlueCard® PPO
Plan Benefits

Imperial Akron Union and Imperial Middleport Union
91317, 91318
BlueCard® PPO

Effective January 01, 2025

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Imperial Akron Union and Imperial Middleport Union
BlueCard® PPO
Effective January 01, 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 (Includes Mental Health Disorders and Substance Abuse)		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible	$250 individual; $500 family The in-network calendar year deductible will *NOT* apply to the out-of-network calendar year deductible.	$500 individual; $1,000 family The out-of-network calendar year deductible *WILL* apply to the in-network calendar year deductible.
Calendar Year 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 allowed amount for remainder of calendar year.	$1,100 individual; $2,200 family All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum, **including prescription drugs.** The in-network out-of-pocket maximum does *NOT* apply to the out-of-network out-of-pocket maximum.	$2,200 individual; $4,400 family Deductibles and coinsurance for out-of-network services (excluding out-of-network mental health disorders and substance abuse emergency services) apply to the out-of-network out-of-pocket maximum, **including prescription drugs.** The out-of-network out-of-pocket maximum *WILL* apply to the in-network out-of-pocket maximum.
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
All hospital admissions require preadmission certification, except maternity admissions as required by Federal law. Emergency admissions require certification within 48 hours of admission except as required by Federal law. For preadmission certification, call 1-800-248-2342.		
Inpatient Hospital and Residential Treatment Facilities **Including:** Residential Treatment Facilities, Skilled Nursing Facilities, Rehabilitation Hospital and Sub-Acute Facilities	Covered at 90% of the allowed amount, subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries	Covered at 70% of the allowed amount, subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries
Human Organ and Tissue Transplant Services (Bone Marrow/Stem Cell)	Covered at 100% of the allowance, no deductible or copay. (*Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowance subject to the calendar year deductible
Inpatient Physician Visits and Consultations	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency) (Copay waived if admitted)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum**
Urgent Care Facility/Outpatient Facility (Copay waived if admitted)	Covered at 100% of the allowed amount, after $10.00 copay per visit copay and subject to calendar year deductible	Covered at 100% of the allowed amount, after $10.00 copay per visit copay and subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Accident) (Copay waived if admitted)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Physician)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to in-network calendar year deductible **Out-of-network Mental Health and Substance Abuse Services apply to the in-network out-of-pocket maximum**
Outpatient Diagnostic Lab, Pathology & X-ray/ER Services (When performed at the Emergency Room)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Outpatient Diagnostic Lab, Pathology & X-ray/Urgent Care (When performed at an Urgent Care Facility)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Outpatient Diagnostic Lab, Pathology & X-ray/Non-ER Services (Includes Pre-admission testing)	Covered at 90% of the allowed amount, subject to calendar year deductible (*Physician's Office Visit is subject to applicable copay per visit*)	Covered at 70% of the allowed amount, subject to calendar year deductible
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/arteriography, CAT Scan, ERCP, MRI, muga-gated cardiac scan & colonoscopy, PET/SPECT & UGI endoscopy (When performed at the Emergency Room)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/arteriography, CAT Scan, ERCP, MRI, muga-gated cardiac scan & colonoscopy, PET/SPECT & UGI endoscopy (When performed at an Urgent Care Facility)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may be based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits, Urgent Care Clinics and Consultations Includes: • Diagnosis for obesity • Surgery performed in the Physician's Office • Second Opinion Consultations • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office) • Specialist office visit	Covered at 100% of the allowed amount after a $10.00 office visit copay per visit with general practitioner, family practitioner, internist, OB/GYN, pediatrician, geriatrics, mental health and substance abuse provider and nurse practitioner or physician's assistant under the direction of above listed providers.	Covered at 70% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Maternity Care (Includes Dependents)	Covered at 90% of the allowed amount, subject to calendar year deductible (100% no deductible or copay for routine prenatal services)	Covered at 70% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/Arteriography, CAT Scan, Colonoscopy, ERCP, MRI, Muga-gated cardiac scan, PET/SPECT & UGI endoscopy	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy **Note:** Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowed amount after a $10.00 office visit copay per visit for Behavioral Therapy services	Covered at 70% of the allowed amount, subject to calendar 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 (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services See **AlabamaBlue.com/PreventiveServices** for a listing of the specific 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	Covered at 70% of the allowed amount, subject to calendar year deductible
Additional Routine Services • Urinalysis – limited to one per calendar year • Complete Blood Count (CBC) – limited to one per calendar year • Cholesterol – limited to one each per calendar year (Includes cholesterol, HDL, LDL, VLDL & Triglycerides) • Blood Glucose and Hemoglobin A1C – limited to one each per calendar year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 70% of the allowed amount, subject to calendar 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 (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drugs are administered by CVS Caremark.		
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. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may be based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Ambulance Service	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 60 visits per member per calendar year	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Obesity/Bariatric Surgery (Subject to medical necessity and clinical guidelines) **Note:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only the Surgical Services accumulate to the lifetime maximum • $10,000 lifetime maximum will apply to Surgical Professional Services	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Genetic Testing/Counseling Genetic Counseling limited to 3 visits per member per calendar year for pre and post-genetic testing	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy • Limited to a maximum of 60 visits per member per calendar year for each therapy • No age or visit limitations for autism spectrum disorders	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy • Limited to a maximum of 60 visits per member per calendar year for each therapy • No age or visit limitations for autism spectrum disorders	Covered at 100% of the allowed amount, after $10.00 copay per visit	Covered at 70% of the allowed amount, subject to calendar year deductible
Pulmonary Rehabilitation & Cognitive Therapy Limited to a combined maximum of 180 days per member per calendar year	Covered at 100% of the allowed amount, after $10.00 per visit copay	Covered at 70% of the allowed amount, subject to calendar year deductible
Cardiac Rehabilitation Therapy Limited to a maximum of 36 days per member per calendar year	Covered at 100% of the allowed amount, after $10.00 per visit copay	Covered at 70% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical and Non-Surgical • Excludes appliances and orthodontic treatment • $1,000 lifetime maximum per member will apply to Non-Surgical TMJ Services	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Diabetic Education Limited to 3 visits per member per calendar year	Covered at 90% of the allowed amount, subject to calendar year deductible *(Physician's Office Visit will be subject to applicable copay per visit)*	Covered at 70% of the allowed amount, subject to calendar year deductible
Hospice (Includes Bereavement Counseling) Precertification required. Call 1-800-821-7231. Services must be authorized by physician	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Home Health (Includes outpatient private duty nursing when approved as medically necessary) Precertification required. Call 1-800-821-7231.	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Home Infusion	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Foot Care (Podiatry) Excluding routine foot care	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Travel and Lodging (Organ Transplants)	Travel and Lodging will be provided for members that live more than 50 miles from approved facilities such as a Center of Excellence or Blue Distinction Center for the treatment of Congenital Heart Disease (CHD), obesity surgery, transplants and cancer related treatments. If the patient is covered by Medicare, benefits for travel and lodging will not be covered. Coverage is allowed for the patient and one companion unless the patient is an enrolled dependent minor child, then the patient and two companions are eligible. Benefits are paid at a per diem rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion or two companions if the patient is a dependent minor child. A combined overall maximum of $10,000 per member in a lifetime. Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.	

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, 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: injectables, 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 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, 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.