We cover what matters.

BlueCard® PPO
Plan Benefits

Nektar Therapeutics
BlueCard® PPO-
HSA Qualified HDHP

Effective January 01, 2025

Visit our website at
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BlueCross BlueShield of Alabama

Nektar Therapeutics
BlueCard® PPO - HSA Qualified HDHP
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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.		
HEALTH SAVINGS ACCOUNT (HSA)		
A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.		
Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The 2025 maximum contribution is **$4,300** for single coverage and **$8,550** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.		
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 The in-network and out-of-network calendar year deductibles are separate and do not apply to each other. For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount.	$1,650 self-only coverage; $3,300 family coverage	$1,650 self-only coverage; $3,300 family coverage
Calendar Year Out-of-Pocket Maximum The in-network and out-of-network calendar year out-of-pocket maximums are separate and do not apply to each other	$1,650 self-only coverage; $3,300 family coverage Deductibles, copays and coinsurance for in-network services and out-of-network Mental Health Disorders and substance abuse emergency services apply to the in-network out-of-pocket maximum The dollar amount of any specialty drug financial assistance provided by providers or manufacturers will not apply to the in-network out-of-pocket maximum After the family Calendar Year Out-of-Pocket Maximum if met, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year	$1,650 self-only coverage; $3,300 family coverage Deductibles and coinsurance for out-of-network services (excluding out-of-network mental health disorders/substance abuse emergency services and out-of-network occupational therapy, physical therapy, speech therapy and DME in Alabama) apply to the out-of-network out-of-pocket maximum After the family Calendar Year Out-of-Pocket Maximum if met, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services and 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 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 **In Alabama,** covered at 50% 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; please see benefit booklet. 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 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Emergency Room (Medical Emergency)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 90% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Accident) **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above.	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible for services rendered within 72 hours; covered at 70% of the allowed amount, subject to the calendar year deductible when services are rendered after 72 hours of the accident and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 90% of the allowed amount, subject to in-network calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, 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 **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Office 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program - Medical and Behavioral Health To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-800-997-6196. Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues.	Covered at 90% of the allowed amount, subject to calendar year deductible	Not Covered
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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Maternity 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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ StandardACAPreventiveDrugList** for listing of specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/ VaccineNetworkDrugList** for more information	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Additional HSA Preventive Medical Services Blood Pressure Monitor • One every 5 years for member diagnosed with hypertension Peak Flow Meter • One annually for member diagnosed with asthma International Normalized Ratio (INR) Testing • Maximum of 15 per year for member diagnosed with liver disorder and/or bleeding disorder Lipoprotein (LDL) Testing • Maximum of 5 per year for member diagnosed with heart disease Hemoglobin A1C Testing • Maximum of 4 per year for member diagnosed with diabetes Retinopathy Screening • Maximum of 3 per year for member diagnosed with diabetes	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 Prepaid Benefits The retail pharmacy network for the plan is **Prime Participating Retail Network** • Locate a **Prime Participating Retail Network** pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator** Retail drugs - up to a 30-day supply • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the **Standard** drug list that applies to the plan at **AlabamaBlue.com/ StandardDrugList** The only in-network pharmacy for some specialty drugs is the **Pharmacy Select Network** • Specialty drugs can be dispensed for up to a 30-day supply • View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList** Some immunizations may be received from an in-network pharmacy that participates in the Pharmacy Vaccine Network. A list of the eligible vaccines these pharmacies may provide can be found at: **AlabamaBlue.com/ VaccineNetworkDrugList**.	Covered at 100% of the allowed amount, subject to the calendar year deductible and following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $30 copay per prescription **Tier 3 Drugs:** $50 copay per prescription Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	Not Covered
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/ SelectGenericSpecialtyandBiosimilarDrugList**. Generic specialty and biosimilar drugs are not available through the Home Delivery Network.	100% of the allowed amount, subject to the calendar year deductible	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Mail Order Pharmacy Benefits • Up to a 90-day supply with one copay • Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/ HomeDeliveryNetwork** Maintenance and Non-Maintenance drugs can be purchased through this mail order pharmacy • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the **Standard** drug list that applies to the plan at **AlabamaBlue.com/ StandardDrugList** • Specialty Drugs are not available through mail order **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 calendar year deductible and following copays: **Tier 1 Drugs:** $10 copay per prescription **Tier 2 Drugs:** $60 copay per prescription **Tier 3 Drugs:** $100 copay per prescription Covered Insulin Products: $99.00 maximum cost share per 30-day supply. When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	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 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
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	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
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 **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Assisted Reproductive Technology Infertility Testing and Treatment (including fertility drugs) are limited to a maximum payment of $30,000 per Individual per lifetime	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 90% of the allowed amount, subject to calendar year deductible
Home Health and Hospice	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Home Infusion	Covered at 100% of the allowed amount, after $50.00 copay and subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
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: 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 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 , 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.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*
- *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

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 બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (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।

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 ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ຟຣີເຊ່ນກັນ. 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.