*We cover what matters.*

# BlueCard® PPO Plan Benefits

## Nektar Therapeutics

BlueCard® PPO

Effective January 01, 2025

Visit our website at
**AlabamaBlue.com**

BlueCross BlueShield of Alabama

# Nektar Therapeutics
## 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** | $200 individual | |
| **Calendar Year Out-of-Pocket Maximum**<br>**Applies to:**<br>• Other Covered Services (The coinsurance for true major medical (DME, physical therapy, etc. except out-of-network occupational therapy, physical therapy, speech therapy and DME in Alabama.)<br>• Home Health and Hospice | $400 individual plus calendar year deductible<br>Only the coinsurance amounts you pay for the listed services will apply to the maximum. Fixed copays do not apply to the maximum.<br>After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% of the allowed amount for the remainder of the 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**<br>**Note:** Inpatient hospital deductibles and copays do not apply to the Calendar Year Out-of-Pocket Maximum. | Covered at 100% of the allowed amount, after $100.00 per admission deductible; no copay required | Covered at 80% of the allowed amount, after $200.00 per admission deductible<br>**Note:** In Alabama, available only for medical emergency services and accidental injury |
| **Inpatient Physician Visits and Consultations** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible<br>**Mental Health Disorders and Substance Abuse Services** covered at 80% of the allowed amount, no copay or 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 100% of the allowed amount, after $50.00 hospital copay | Covered at 80% of the allowed amount, subject to calendar year deductible<br>**In Alabama,** not covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Emergency Room (Medical Emergency)** | Covered at 100% of the allowed amount, after $50.00 hospital copay | Covered at 100% of the allowed amount, after $50.00 hospital copay<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $50.00 hospital copay |
| **Emergency Room (Accident)** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 100% of the allowed amount, no copay or deductible |
| **Emergency Room (Physician)** | Covered at 100% of the allowed amount, after $20.00 physician copay | Covered at 100% of the allowed amount, after $20.00 physician copay<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $20.00 physician copay |
| **Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services** | Covered at 100% of the allowed amount, after $20.00 daily hospital copay | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**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 & Consultations** | Covered at 100% of the allowed amount, after $20.00 physician copay | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Telephone and Online Video Physician Consultations Program - Medical and Behavioral Health**<br>To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-800-997-6196.<br><br>Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues. | Covered at 100% of the allowed amount, subject to $20.00 payment per consultation | Not Covered |
| **Second Surgical Opinions** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Surgery & Anesthesia** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Maternity Care** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Applied Behavioral Analysis (ABA) Therapy**<br>Limited to ages 0-18 for autism spectrum disorders | Covered at 100% of the allowed amount, after $20.00 copay | Covered at 80% of the allowed amount, subject to calendar year deductible |
| **PREVENTIVE CARE BENEFITS** | | |
| **Routine Newborn Exam (in hospital)** | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Well Child Care Exams**<br>Nine visits the first two years of life, then one each year through age 6 | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Routine Developmental Screening**<br>Limited to three exams between 9 and 30 months of life | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Immunizations**<br>• Age limitations apply to certain immunizations<br>• 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 |
| **Routine Office Visit**<br>When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Pap Smear**<br>Limited to one per member per calendar year | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Human Papillomavirus (HPV) Testing**<br>Limited to one every three calendar years for members ages 30 and older | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Chlamydia Screening**<br>Limited to one per calendar year for members ages 15-24 | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine/Screening Mammogram**<br>Limited to one baseline between ages 35 and 39; and one annually ages 40 and over | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Prostate Cancer Screening**<br>Members age 40 and over<br>• Prostate Specific Antigen (PSA) each calendar year<br>• Digital Rectal Exam each calendar year | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Routine Hepatitis C Screening**<br>Once in a lifetime for members born between 01/01/1945 and 12/31/1965 | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Routine Colorectal Cancer Screening**<br><br>Limited to the following for members age 45 and over:<br>• Hemocult stool check/Fecal occult blood test each calendar year<br>• FIT-DNA (cologuard) ages 45-99 every three calendar years<br>• Flexible sigmoidoscopy every three calendar years<br>• Double-contrast barium enema every five calendar years<br>• Colonoscopy every 10 calendar years | Covered at 100% of the allowed amount, no copay or deductible for physician charges (outpatient hospital services may require a copay) | Not Covered |
| **Note:** In case of Illness or family history of cancer services generally are not considered preventive and may be covered by other plan provisions. Blue Cross and Blue Shield of Alabama will process these claims are required by Section 1557 of the Affordable Care Act. | | |
| **PRESCRIPTION DRUG BENEFITS**<br>**(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**<br><br>The retail pharmacy network for the plan is **Prime Participating Retail Network**<br><br>• Locate a **Prime Participating Retail Network** pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator**<br><br>Maintenance drugs - up to 60-day supply at retail with one copay<br>• View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList**<br><br>Prescription drugs (other than maintenance drugs) - up to a 34-day supply<br>• Some copays combined for diabetic supplies<br>• View the **Standard** drug list that applies to the plan at **AlabamaBlue.com/ StandardDrugList**<br><br>The only in-network pharmacy for some specialty drugs is the **Pharmacy Select Network**<br>• Specialty drugs can be dispensed for up to a 30-day supply<br>• View the Specialty Drug List at **AlabamaBlue.com/SelfAdministered SpecialtyDrugList**<br><br>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**.<br><br>Benefits are provided for Oral, injectable, and transdermal contraceptives | Covered at 100% of the allowed amount, subject to the following copays for each prescription:<br><br>**Tier 1 Drugs:**<br>$10 copay per prescription<br><br>**Tier 2 Drugs:**<br>$20 copay per prescription<br><br>**Tier 3 Drugs:**<br>$35 copay per prescription<br><br>Covered Insulin Products: $99.00 maximum cost share per 30-day supply. | Not Covered |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Select Generic Specialty and Biosimilar Drugs**<br><br>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.**<br><br>• View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at **AlabamaBlue.com/ SelectGenericSpecialtyandBiosimilarDrugList**.<br><br>Generic specialty and biosimilar drugs are not available through the Home Delivery Network. | 100% of the allowed amount, no deductible or copayment | 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 80% 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**<br><br>Limited to 12 visits per member per 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 |
| **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<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Rehabilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per 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<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Habilitative Occupational, Physical and Speech Therapy**<br><br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per 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<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Occupational, Physical and Speech Therapy for Autism Spectrum Disorders 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<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible |
| **Home Health and Hospice** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Home Infusion** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 80% of the allowed amount, subject to calendar year deductible<br><br>**In Alabama,** not covered |
| **Assisted Reproductive Technology**<br><br>Infertility Testing and Treatment (including fertility drugs) are limited to a maximum payment of $30,000 per Individual per lifetime | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 80% of the allowed amount, subject to calendar year deductible |
| **Medical Nutrition Therapy Services**<br><br>For adults and children, limited to 6 hours per member per calendar year | Covered at 100% of the allowed amount, after $20.00 copay | Covered at 80% of the allowed amount, subject to calendar year deductible |
| **EXPANDED PSYCHIATRIC SERVICES (EPS)** | | |
| **Expanded Psychiatric Services (EPS)**<br>• EPS network is available throughout Alabama and in Meridian, Mississippi and Northwest Florida.<br>• To find an EPS provider call Customer Service at 1-800-292-8868 or search the online provider on our website at **AlabamaBlue.com** | When care is received or coordinated by an EPS provider, the following mental health disorders and substance abuse benefits are available:<br><br>Covered at 100% of the allowed amount; no copay or deductible<br>**Inpatient:** Includes hospital, physician and therapy expenses<br>**Outpatient:** Includes office visits, therapy, counseling and testing<br><br>When care is not received or coordinated by an EPS provider, the mental health disorders and substance abuse benefit levels are not separately stated. Please refer to the appropriate subsections above and below that relate to the services or supplies you receive, such as Inpatient Hospital Benefits, Outpatient Hospitals Benefits, etc. | |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **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. | |
| **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. | |

***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). 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.*
- *In-network Certified Registered Nurse practitioners (CRNPs) /Certified Nurse Midwives (CNMs) are considered eligible providers; no coverage out-of-network for services provided by CRNPs and CNMs.*
- *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 transportation 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 transportation 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 transportation 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.*

**Your group believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information. Please visit our website at 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.