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BlueCard® PPO Plan Benefits

Samford University Student Health Plan

BlueCard® PPO

Effective August 21, 2024

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BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Samford University Student Health Plan
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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.		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Plan year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Plan Year Deductible August 21, 2024 - August 20, 2025 The in-network and out-of-network plan year deductibles are separate and do not apply to each other	$200 individual;	$600 individual;
Plan Year Out-of-Pocket Maximum August 21, 2024 - August 20, 2025 The in-network and out-of-network Plan Year out-of-pocket maximums are separate and do not apply to each other	$6,850 individual; $13,700 family All deductibles, copays and coinsurance for in-network services and all deductibles, copay and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the 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 you reach your Plan Year Out-of-Pocket maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of plan year.	$15,000 individual; Coinsurance for out-of-network services (excluding out-of-network mental health disorders and 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 you reach your Plan Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of plan 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 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **Note:** In Alabama, available only for medical emergency services and accidental injury.
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, after $150.00 hospital copay	Covered at 100% of the allowed amount, after $150.00 hospital copay **Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $150.00 hospital copay
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 100% of the allowed amount, after $150.00 hospital copay	Covered at 100% of the allowed amount, after $150.00 hospital copay for services rendered within 72 hours; covered at 60% of the allowed amount, subject to plan 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 100% of the allowed amount, after $50.00 copay	Covered at 100% of the allowed amount, after $50.00 copay **Mental Health Disorders and Substance Abuse Services** Covered at 100% of the allowed amount, after $50.00 copay
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Student Health Center	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Second Surgical Opinions	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Urgent Care	Covered at 100% of the allowed amount, after $50.00 copay	Covered at 100% of the allowed amount, after $50.00 copay
Surgery & Anesthesia	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Maternity Care	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ SourceRxPreventiveDrugList** 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
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.		
PEDIATRIC VISION BENEFITS		
Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.		
Pediatric Eye Exam Limited to one exam (including refraction) per member per plan year up to the end of the month in which the member turns 19.	Covered at 100% of the allowed amount, after $20.00 copay per visit	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eyeglass Lenses Limited to one per member per plan year	Covered at 100% of the allowed amount, after $40.00 copay per visit	Covered at 50% of the allowed amount, subject to plan year deductible
Additional Lens Limited to one per member per plan year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost up to $130.	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost of $130-$160.	Covered at 100% of the allowed amount, after $15.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost of $160-$200.	Covered at 100% of the allowed amount, after $30.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost of $200-$250.	Covered at 100% of the allowed amount, after $50.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Pediatric Eye Glass Frames Limited to one pair of prescription glasses per member per plan year with a retail cost greater than $250.	Covered at 60% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Pediatric Contact Lenses Fittings & Evaluation Limited to one per plan year	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Pediatric Contact Lenses Limited to one 12-month supply per plan year	Covered at 100% of the allowed amount, after $40.00 copay	Covered at 50% of the allowed amount, subject to plan year deductible
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** Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** Prescription drugs (other than maintenance drugs) - up to a 30-day supply • Some copays combined for diabetic supplies • View the **Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourcePlusRx1DrugList6T** The only in-network pharmacy for some Tiers 5 & 6 (specialty) drugs is the **Pharmacy Select Network** • Tier 6 (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 following copays for a 30-day supply for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $15 copay per prescription **Tier 3 Drugs:** $35 copay per prescription **Tier 4 Drugs:** $60 copay per prescription **Tier 5 (specialty) Drugs:** $120 copay per prescription **Tier 6 (specialty) Drugs:** $120 copay per prescription 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 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.	Covered at 100% of the allowed amount, no deductible or copayment	Not Covered
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** Only maintenance drugs can be purchased through this mail order pharmacy service • View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • View the **Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/ SourcePlusRx1DrugList6T** **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 Drugs:** $37.50 copay per prescription **Tier 2 Drugs:** $37.50 copay per prescription **Tier 3 Drugs:** $87.50 copay per prescription **Tier 4 (specialty) Drugs:** $150 copay per prescription **Tier 5 (Preferred specialty) Drugs:** Not covered **Tier 6 (Non-Preferred specialty) Drugs:** Not covered Covered Insulin Products: $99.00 maximum cost share per 30-day supply.	Not Covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible
Ambulance Service	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 80% of the allowed amount, subject to plan year deductible
Participating Chiropractic Services	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible
Home Health and Hospice	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Infusion	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible **In Alabama,** not covered
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per plan year	Covered at 80% of the allowed amount, subject to plan year deductible	Covered at 60% of the allowed amount, subject to plan year deductible
PEDIATRIC DENTAL BENEFITS		
Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.		
Diagnostic and Preventive Services **Limited to 2 times per 12 months** **Examples include:** **Limited to 2 times per 12 months** Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish **Basic Services** **Examples include:** Tooth color and silver amalgam fillings, simple tooth extractions, non-surgical root canal, emergency treatment for pain and repairs to crowns, inlays, onlays (limited to 1 time every 60 months) and dentures **Major Services** **Limited to 1 time every 60 months** **Examples include:** Oral surgery, general anesthesia, periodontic exams, removal of diseased gum tissue and bone, crowns, onlays, core buildup, dentures, implants and bridges	Covered at 50% of the allowed amount, subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible
Medically Necessary Orthodontic Services	Covered at 50% of the allowed amount subject to plan year deductible	Covered at 50% of the allowed amount, subject to plan year deductible

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). 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.*
- *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.*
- *As a participant in the student health plan, you have access to the following services and benefits when you are traveling over 100 miles from home or outside your community: Emergency Medical Evacuation, Repatriation and Emergency Family Assistance Services, Medical, Travel, Safety, and Legal Assistance and additional benefits. Please visit **aes.myahpcare.com** for more information.*
- *AHP Live Care is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to allow you to see board certified professionals discreetly and on your terms at no additional cost. To access these services, please visit **ahplivecare.com** and use the service key and coupon code **AHPFREE**.*
- *Student Assistance Program allows 24/7 access, life and wellbeing resources, online and mobile tools are that are free, if you referred to outside resources, you will be responsible for any costs. For more information, please call 1(855)850-4301.*
- *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.*

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

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

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

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

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711）。

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

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

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

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

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

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કૉલ કરો (TTY: 711).

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

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

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

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

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

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

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

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

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。