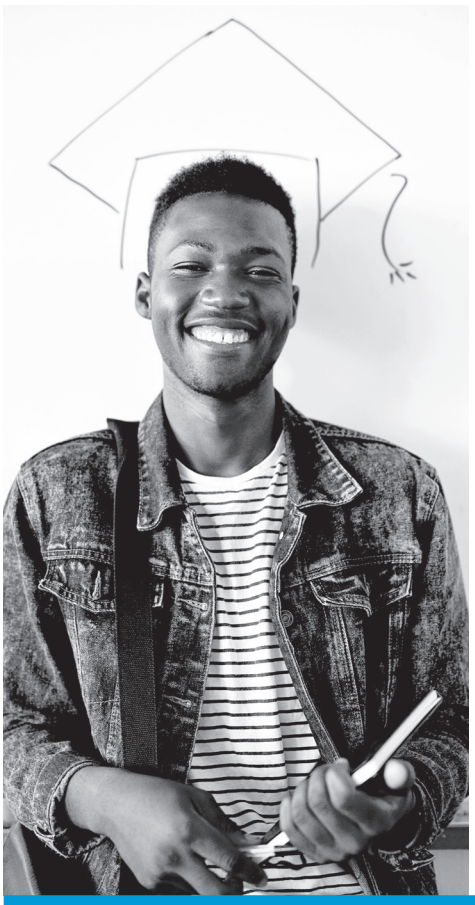
BlueCross BlueShield of Alabama



**BlueCard PPO**

Visit our website at **AlabamaBlue.com**

# Student Health Plan Benefits
# Tuskegee University Student Health Plan
## BlueCard® PPO

Effective August 1, 2024



MKT348-23112

# Tuskegee University Student Health Plan
## BlueCard® PPO
## Effective August 1, 2024

| 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.** | | |
| **Plan Year Deductible**<br>August 1, 2024 -August 11, 2025<br>The in-network and out-of-network Plan Year Deductibles are separate and do not apply to each other | $150 individual | $750 individual |
| **Plan Year Out-of-Pocket Maximum**<br>August 1, 2024 -August 11, 2025<br>The in-network and out-of-network Plan Year out-of-pocket maximums are separate and do not apply to each other | $6,600 individual; $13,200 family<br>All 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 and out-of-network out-of-pocket maximum<br>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<br>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 | $13,200 individual; $26,400 family<br>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<br>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 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**Note:** In Alabama, available only for medical emergency services and accidental injury |
| **Inpatient Physician Visits and Consultations** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**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 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**In Alabama,** not covered |
| **Emergency Room (Medical Emergency)**<br><br>**Note: Copay will be waived if admitted to the hospital** | Covered at 100% of the allowed amount, after $200.00 hospital copay | Covered at 100% of the allowed amount, after $200.00 hospital copay<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $200.00 hospital copay |
| **Emergency Room (Accident)**<br><br>**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.<br><br>**Note: Copay will be waived if admitted to the hospital** | Covered at 100% of the allowed amount, after $200.00 hospital copay | Covered at 100% of the allowed amount, after $200.00 hospital copay for services rendered within 72 hours; covered at 70% of the allowed amount, subject to the 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 $15.00 physician copay | Covered at 100% of the allowed amount, after $15.00 physician copay<br><br>**Mental Health Disorders and Substance Abuse Services** covered at 100% of the allowed amount, after $15.00 physician copay |
| **Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**In Alabama,** not covered |
| **Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**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 & Consultations** | Covered at 100% of the allowed amount, after $15.00 physician copay | Covered at 100% of the allowed amount, after $20.00 physician copay and subject to plan year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |
| **Student Health Center**<br><br>Note: The student must use the services of the Health Center first where outpatient treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each injury or Sickness per Policy Year.<br><br>Referral for outside care is not necessary only under the following conditions:<br>• Medical Emergency<br>• SHC is closed<br>• Service is rendered at another facility during break or vacation periods<br>• Medical care received when the student is more than 30 miles from campus<br>• Medical care obtained when student is no longer able to use the SHC due to a change in student status<br>• Maternity, obstetrical and gynecological care<br>• Mental illness and Substance Use Disorder treatment<br>• Dental Services do not require a referral from the Student Health Clinic<br><br>Dependents are not eligible | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| **Second Surgical Opinions** | Covered at 100% of the allowed amount, after $15.00 physician copay | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |
| **Surgery & Anesthesia** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Maternity Care** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**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 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br><br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |
| **Applied Behavioral Analysis (ABA) Therapy**<br>Limited to ages 0-18 for autism spectrum disorders | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible |
| **PREVENTIVE CARE BENEFITS** | | |
| **Routine Immunizations and Preventive Services**<br>• 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<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 |
| **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**<br><br>The retail pharmacy network for the plan is **Prime Participating Network**<br>• Locate a **Prime Participating** Network pharmacy at **AlabamaBlue.com/ PrimeParticipatingPharmacyLocator**<br><br>Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply<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 30-day supply<br>• Some copays combined for diabetic supplies<br>• View the **2024 Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/2024SourcePlusRx1DrugList**<br><br>The only in-network pharmacy for some Tiers 5 & 6 (specialty) drugs is the **Pharmacy Select Network**<br>• Tier 5 & 6 (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**. | Covered at 100% of the allowed amount, subject to the following copays for a 30-day supply for each prescription:<br><br>**Tier 1 Drugs:**<br>$5 copay per prescription<br><br>**Tier 2 Drugs:**<br>$5 copay per prescription<br><br>**Tier 3 Drugs:**<br>$25 copay per prescription<br><br>**Tier 4 Drugs:**<br>$40 copay per prescription<br><br>**Tier 5 (specialty) Drugs:**<br>$80 copay per prescription<br><br>**Tier 6 (specialty) Drugs:**<br>$80 copay per prescription<br><br>Covered Insulin Products: $99 maximum cost share per 30-day supply. | Not Covered |
| **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>• 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 |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Mail Order Pharmacy Benefits**<br>• Up to a 90-day supply with one copay<br>• Mail Order Drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/ HomeDeliveryNetwork**<br><br>Only maintenance drugs can be purchased through this mail order pharmacy service<br>• View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList**<br>• View the **2024 Source+Rx 1.0** drug list that applies to the plan at **AlabamaBlue.com/2024SourcePlusRx1 DrugList**<br><br>**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:<br><br>**Tier 1 Drugs:**<br>$12.50 copay per prescription<br><br>**Tier 2 Drugs:**<br>$12.50 copay per prescription<br><br>**Tier 3 Drugs:**<br>$62.50 copay per prescription<br><br>**Tier 4 Drugs:**<br>$100 copay per prescription<br><br>**Tier 5 (Preferred specialty) Drugs:**<br>Not covered<br><br>**Tier 6 (Non-Preferred specialty) Drugs:**<br>Not covered<br><br>Covered Insulin Products: $99 maximum cost share per 30-day supply. | Not Covered |
| **VISION BENEFITS** | | |
| **Pediatric Routine Vision Examination**<br>Limited to one per member per plan year for routine vision exam or refraction only in lieu of a complete exam | Covered at 100% of the allowed amount, after $20.00 copay | Covered at 50% of the allowed amount, subject to plan year deductible |
| **Pediatric Eyeglass Lenses**<br>Limited to one per member per plan year<br>**Note: Member can select either frames or contact lenses** | Covered at 100% of the allowed amount, after $40.00 copay | Covered at 50% of the allowed amount, subject to plan year deductible |
| **Lens Extras** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 100% of the allowed amount, subject to plan year deductible |
| **Pediatric Eyeglass Frames**<br>Limited to one pair of prescription glasses per member per plan year with a retail cost up to $130.<br><br>**Note: Member can select either frames or contact lenses** | 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**<br>Limited to one pair of prescription glasses per member per plan year with a retail cost up to $130-$160.<br><br>**Note: Member can select either frames or contact lenses** | Covered at 100% of the allowed amount, after $15.00 copay | Covered at 50% of the allowed amount, subject to plan year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Pediatric Eye Glass Frames**<br>Limited to one pair of prescription glasses per member per plan year with a retail cost up to $160-$200.<br>**Note: Member can select either frames or contact lenses** | 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**<br>Limited to one pair of prescription glasses per member per plan year with a retail cost up to $200-$250.<br>**Note: Member can select either frames or contact lenses** | Covered at 100% of the allowed amount, after $50.00 copay | Covered at 50% of the allowed amount, subject to plan year deductible |
| **Pediatric Eye Glass Frames**<br>Limited to one pair of prescription glasses per member per plan year with a retail cost greater than $250.<br>**Note: Member can select either frames or contact lenses** | 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 Fitting & Evaluation**<br>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 |
| **Pediatrics Contact Lenses**<br>Limited to one 12-month supply per plan year<br>**Note: Member can select either frames or contact lenses** | Covered at 100% of the allowed amount, after $40.00 copay | Covered at 50% of the allowed amount, subject to plan year deductible |
| **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 plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible |
| **Ambulance Service** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 100% of the allowed amount, no copay or deductible |
| **Participating Chiropractic Services** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** not covered |
| **Durable Medical Equipment (DME)** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Rehabilitative Occupational, Physical and Speech Therapy**<br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |
| **Habilitative Occupational, Physical and Speech Therapy**<br>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per plan year | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**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 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** covered at 50% of the allowed amount, subject to plan year deductible |
| **Home Health and Hospice** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** not covered |
| **Home Infusion** | Covered at 90% of the allowed amount, subject to plan year deductible | Covered at 70% of the allowed amount, subject to plan year deductible<br>**In Alabama,** not covered |
| **Medical Nutrition Therapy Services**<br>For adults and children, limited to 6 hours per member per calendar year | Covered at 100% of the allowed amount, after $15.00 copay | Covered at 100% of the allowed amount, after $20.00 copay |
| **Pediatric Dental Benefits** | Covered at 50% of the allowed amount, subject to plan year deductible | Covered at 50% of the allowed amount, subject to plan year deductible |
| **Annual Dental Exam & Cleaning**<br>Benefits paid for one annual exam and cleaning up to $100 per Plan Year | Covered at 100% of the allowed amount, no copay or deductible | Covered at 100% of the allowed amount, subject to plan year deductible |
| **Medically Necessary Removal of Impacted Wisdom Teeth** | Covered at 100% of the allowed amount, no copay or deductible | Covered at 100% 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 or the average charge for care in the area.*
- *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 services 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。