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BlueCard[®] PPO Plan Benefits

**Dixie Group
Blue Secure PPO
BlueCard[®] PPO**

Effective January 1, 2021



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

**Dixie Group
Blue Secure PPO
BlueCard® PPO
Effective January 1, 2021**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p><i>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.</i></p>		
<p>SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)</p>		
<p>Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other</p>	\$1,000 individual; \$2,000 family	\$2,000 individual; \$4,000 family
<p>Calendar Year Out-of-Pocket Maximum All deductibles, copays and coinsurance for in-network services and all deductibles, copays and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum. Available manufacturer or provider cost share assistance program payments made with respect to the specialty drugs on the Specialty Drug Coupon Program List do not apply to the in-network out-of-pocket maximum.</p>	<p>\$6,000 individual; \$12,000 family After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year</p>	There is no out-of-pocket maximum for out-of-network services.
<p>INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)</p>		
<p>Precertification is required for inpatient admissions (except medical emergency services and maternity); 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.</p>		
<p>Inpatient Hospital</p>	Covered at 90% of the allowed amount, after \$250.00 per day hospital copay days 1-5 for each admission	<p>Covered at 50% of the allowed amount, after \$1,200 per admission deductible Note: In Alabama, available only for medical emergency services and accidental injury</p>
<p>Inpatient Physician Visits and Consultations</p>	<p>Covered at 90% of the allowed amount, subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount, no copay or deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 50% of the allowed amount, no copay or deductible</p>
<p>Organ Transplants Must be performed in a Blue Distinction Specialty Care Facility</p>	Covered at 100% of the allowed amount, after \$250.00 per day hospital copay days 1-5 for each admission	Not covered
<p>Travel and Lodging Expenses for Organ Transplants Only</p> <ul style="list-style-type: none"> • Eligible for the following treatment <ul style="list-style-type: none"> ○ Organ transplant Participant-Please refer to your benefit booklet for details or contact Customer Service for details of coverage ○ Limited to \$10,000 maximum per transplant • Limited to patient and one companion • Daily maximums: <ul style="list-style-type: none"> ○ \$50 per member and \$100 total for member and companion • Includes airfare, tolls/parking fees, apartment rental, hotel rental, tax, gas/mileage (mileage reimbursed at the current government rate) • Member must live more than 50 miles from the transplant facility to be eligible 	Covered at 100% of the allowed amount, no copay or deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Spinal Surgery Must be performed in a Blue Distinction Specialty Care Facility	Covered at 100% of the allowed amount, no copay or deductible	Not covered
Knee & Hip Replacement (Outside Alabama) Must be performed in a Blue Distinction Specialty Care Facility	Covered at 100% of the allowed amount, no copay or deductible	Not covered
Knee & Hip Replacement (In Alabama) Must be performed in a Blue Achievement Specialty Care Facility or Blue Distinction Specialty Care Facility	Covered at 100% of the allowed amount, no copay or deductible	Not covered
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits. 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 50% of the allowed amount, subject to calendar year deductible In Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount, after \$350.00 hospital copay	Covered at 100% of the allowed amount, after \$350.00 hospital copay and subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount, after \$350.00 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 \$350.00 hospital copay	Covered at 100% of the allowed amount, after \$350.00 hospital copay and subject to calendar year deductible for services rendered within 72 hours; 50% 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 100% of the allowed amount, after \$60.00 physician copay	Covered at 100% of the allowed amount, after \$60.00 physician copay and subject to calendar year deductible Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount, after \$60.00 physician copay
Outpatient Diagnostic Lab, Pathology & X-ray Note: Covered routine mammograms not subject to hospital copay	Covered at 90% of the allowed amount, after \$250.00 hospital copay	Covered at 50% of the allowed amount, subject to calendar year deductible In Alabama, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Angiography/Arteriography, Cardiac cath/Arteriography, CAT Scan, Colonoscopy, ERCP, MRI, Muga-gated cardiac scan, PET/SPECT & UGI endoscopy	Covered at 90% of the allowed amount, after \$250.00 copay per procedure	Covered at 50% of the allowed amount, subject to calendar year deductible In Alabama, not covered
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible 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 calendar year deductible	Covered at 50% 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. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList.
If precertification is not obtained, no benefits are available.

Office Visits and In-Person Consultations	Covered at 100% of the allowed amount, after \$40.00 primary care physician copay or \$60.00 specialist physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Telephone and Online Video Physician Consultations Program A service, through Teladoc™ to diagnose, treat and prescribe medication (when necessary) for certain medical issues. To enroll, go to Teladoc.com/Alabama or call 1-855-477-4549	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Second Surgical Opinions	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Diagnostic X-ray	Covered at 100% of the allowed amount, after \$10.00 copay per procedure	Covered at 50% of the allowed amount, subject to calendar year deductible
Angiography/Arteriography, Cardiac cath/Arteriography, CAT Scan, Colonoscopy, ERCP, MRI, Muga-gated cardiac scan, PET/SPECT & UGI endoscopy	Covered at 90% of the allowed amount, after \$250.00 copay per procedure	Covered at 50% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care Note: If pregnancy spans into two calendar years only one calendar year deductible will apply	Covered at 90% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services <ul style="list-style-type: none"> • 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 Routine Services	Covered at 100% of the allowed amount, no copay or deductible <ul style="list-style-type: none"> • Urinalysis • Lipid Panel • LDL Cholesterol • Triglycerides • General Health Panel 	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.		
VISION BENEFITS		
Routine Eye Exam <ul style="list-style-type: none"> • Limited to \$75 maximum per person for one exam and refraction every 24 months for adults age 19 and over • Limited to one visit per person for one exam and refraction every 24 months up to age 19 	Covered at 100% of the allowed amount; no copay or deductible	

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.		
<p>Retail Prescription Prepaid Benefits</p> <p>The retail pharmacy network for the plan is Prime Participating Pharmacy Network</p> <ul style="list-style-type: none"> Locate a Prime Participating Pharmacy Network at AlabamaBlue.com/PrimeParticipatingPharmacyLocator <p>Drugs on the Specialty Drug Coupon Program List are subject to the greater of the applicable Tier copay or the full amount of the available manufacturer cost share assistance program payments</p> <ul style="list-style-type: none"> Certain specialty drugs are listed on the Specialty Drug Coupon Program List at AlabamaBlue.com/SpecialtyCouponProgramDrugList <p>Maintenance drugs - up to 90-day supply may be purchased but copay applies for each 30-day supply</p> <ul style="list-style-type: none"> View the maintenance drug list that applies to the plan at AlabamaBlue.com/MaintenanceDrugList <p>Prescription drugs (other than maintenance drugs) - up to a 30-day supply</p> <ul style="list-style-type: none"> Some copays combined for diabetic supplies View the Standard Prescription Drug List that applies to the plan at AlabamaBlue.com/StandardDrugList <p>The only in-network pharmacy for some Tier 4 (specialty) drugs is the Pharmacy Select Network</p> <ul style="list-style-type: none"> Tier 4 (specialty) drugs can be dispensed for up to a 30-day supply View the Specialty Drug List at AlabamaBlue.com/SelfAdministeredSpecialtyDrugList <p>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</p>	<p>Covered at 100% of the allowed amount, subject to the following copays for a 30-day supply for each prescription:</p> <p>Tier 1 Drugs: \$15 copay per prescription</p> <p>Tier 2 Drugs: \$50 copay per prescription</p> <p>Tier 3 Drugs: \$100 copay per prescription</p> <p>Tier 4 (specialty) Drugs: \$250 copay per prescription</p> <p>Tier 4 (Specialty) Drugs on Specialty Drug Coupon Program List: Member cost share is the greater of \$250 copay or the full amount of the available manufacturer or provider cost share assistance program payments (such as manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons).</p> <p>Generic drugs are mandatory when available and may be classified in any Tier</p>	<p>Not Covered</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p>Mail Order Pharmacy Benefits</p> <ul style="list-style-type: none"> Up to a 90-day supply with one copay Mail Order Drugs are available through Home Delivery Network (Enroll online at AlabamaBlue.com/HomeDeliveryNetwork or call 1-800-391-1886) <p>Only maintenance drugs can be purchased through this mail order pharmacy service</p> <ul style="list-style-type: none"> View the maintenance drug list that applies to the plan at AlabamaBlue.com/MaintenanceDrugList View the Standard Prescription Drug list that applies to the plan at AlabamaBlue.com/StandardDrugList <p>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</p>	<p>Covered at 100% of the allowed amount, subject to the following copays:</p> <p>Tier 1 Drugs: \$37.50 copay per prescription</p> <p>Tier 2 Drugs: \$125 copay per prescription</p> <p>Tier 3 Drugs: \$250 copay per prescription</p> <p>Tier 4 (specialty) Drugs: Not covered</p> <p>Generic drugs are mandatory when available and may be classified in any Tier</p>	<p>Not Covered</p>
<p>BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)</p>		
<p>Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.</p>		
<p>Allergy Testing & Treatment</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>
<p>Ambulance Service</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>
<p>Participating Chiropractic Services</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p> <p>In Alabama, not covered</p>
<p>Durable Medical Equipment (DME)</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>
<p>Rehabilitative Occupational, Physical and Speech Therapy</p> <p>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>
<p>Habilitative Occupational, Physical and Speech Therapy</p> <p>Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>
<p>Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18</p>	<p>Covered at 80% of the allowed amount, subject to calendar year deductible</p>	<p>Covered at 50% of the allowed amount, subject to calendar year deductible</p>

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Home Health and Hospice	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible In Alabama, not covered
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.
- Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.
- 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: 한국어 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 નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ 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 नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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。