We cover what matters.

BlueCard® PPO
Plan Benefits

Public Education Employees' Health Insurance Plan (PEEHIP)

PEEHIP
Group 14000
BlueCard® PPO

Effective October 1, 2018

Visit our website at
AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Public Education Employees' Health Insurance Plan (PEEHIP)
BlueCard® PPO

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		
Calendar Year Deductible for Major Medical Services	$300 individual; $900 family maximum	
Calendar Year Out-of-Pocket Maximums	**Major Medical Maximums:** $400 individual annual major medical out-of-pocket maximum (no family maximum) plus the $300 calendar year deductible. In-network Other Covered Services are the only expenses applicable to the calendar year major medical out-of-pocket maximum (includes Participating Chiropractor Services, Physical Therapy, DME, Occupational Hand Therapy, Speech Therapy, Allergy Testing and Treatment, Infertility Services, Preferred Home Health and Hospice, and Ambulance services). **Overall Maximums:** $7,350 individual; $14,700 family contract calendar year overall out-of-pocket maximum All deductibles, copays and coinsurance for in-network services apply to the calendar year overall out-of-pocket maximum, including prescription drugs. After you reach your Calendar Year Out-of-Pocket Maximum (even if you are covered under a family contract), applicable expenses for you will be covered at 100% of the allowed amount for the remainder of the calendar year.	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
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.		
Inpatient Hospital* (including maternity) **Note:** Maternity benefits are not available to dependent children of any age.	Covered at 100% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission copayment and a $25 per day copay for days 2-5 ***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	Covered at 80% of the allowed amount for semi-private room and board; intensive care units, general nursing services and usual hospital ancillaries after a $200 per admission copayment and a $25 per day copay for days 2-5 **Note:** In Alabama, in-patient benefits 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 ***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	Covered at 80% of the allowed amount subject to calendar year deductible
OUTPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
Precertification is required for some outpatient hospital benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery* (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount after $150 facility copay ***Coverage for Bariatric Surgery available only at Alabama Blue Distinction Centers®	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** out-of-network facilities, not covered
Outpatient Surgery & Anesthesia Physician Visits	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Medical Emergency) (In-Area/Out-of-Area) Facility Charge	Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 100% of the allowed amount after $150 facility copay for true medical emergencies. If the diagnosis does not meet medical emergency criteria, covered at 80% of the allowed amount subject to the calendar year deductible.
Emergency Room (Accidental Injury) (In-Area/Out-of-Area) Facility Charge **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **(Medical Emergency)** above.	Covered at 100% of the allowed amount after $150 facility copay	Covered at 100% of the allowed amount after $150 facility copay within 72 hours of the accident; 80% of the allowance, 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 $35 physician copay	Covered at 100% of the allowed amount after $35 physician copay
Outpatient Diagnostic Lab & Pathology	Covered at 100% of the allowed amount after $5 copay per test	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities not covered
Chemotherapy, Dialysis, IV Therapy & Radiation Therapy	Covered at 100% of the allowed amount after $25 facility copay	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities, not covered
Outpatient Diagnostic X-ray	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible **In Alabama,** out-of-network facilities, not covered
PHYSICIAN BENEFITS		
Precertification is required for some physician benefits and provider-administered drugs; please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Office Visits and In-Person Consultations-Primary Care Physician (Includes Urgent Care, Internal Medicine, Family Practice, General Practice, Physician Assistant, Clinic, Gynecology, Obstetrics, Certified Nurse Practitioner, Midwives, and Pediatrician)	Covered at 100% of the allowed amount after a $30 office visit copay	Covered at 80% of the allowed amount subject to the calendar year deductible
Office Visits and In-Person Consultations-Specialist	Covered at 100% of the allowed amount after a $35 office visit copay	Covered at 80% of the allowed amount subject to the 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	Group 14000 members have access to Teladoc® nationwide. Teleconsultation providers other than Teladoc® are not covered
Outpatient 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

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Second Surgical Opinions	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the calendar year deductible
Diagnostic Lab & Pathology	Covered at 100% of the allowed amount after a $5 copay per test	Covered at 80% of the allowed amount subject to the calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Radiation Therapy & X-ray	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to the 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 the calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/ PreventiveServices** and **AlabamaBlue.com/ StandardACAPreventiveDrugList** for listing of specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy.	Covered at 100% of the allowed amount; no copay or deductible. In addition to the standard the following are covered: • Urinalysis (once by age 5 and once between ages 12 through 17) • CBC (once each calendar year) • Cholesterol Screening (once per calendar year for members age 18 and older) • Glucose Screening (once per calendar year for member age 18 and older)	Not Covered
MENTAL HEALTH DISORDERS AND SUBSTANCE ABUSE BENEFITS		
Inpatient Facility Services	Covered at 100% of the allowed amount subject to the following copays: No charge for days 1-9; $15 per day for days 10-14; $20 per day for days 15-19; $25 per day for days 20-24; $30 per day for days 25-30. Covers up to 30 days per person each plan year (10/1-9/30). Inpatient Substance Abuse limited to one admission per plan year and a maximum of two admissions per lifetime. Mental Health and Substance Abuse days are aggregate. No rollover to Major Medical.	Covered at 100% of the allowed amount subject to a $200 per admission copayment and a $25 per day copay for days 2-5. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required.
Inpatient Physician Services	Covered at 80% of the allowed amount subject to the calendar year deductible. Coverage is available only during a covered admission up to 30 days per plan year.	Covered at 80% of the allowed amount, subject to the calendar year deductible. Provides coverage only for short-term crisis intervention and only until the patient is stable enough to be moved to a PPO hospital. Precertification is required.
Outpatient Physician Services at PEEHIP Certified Community Mental Health Centers	Covered at 100% of the allowed amount subject to a $10 copay per visit. Limited to 20 visits per member each plan year. Maximum visits are combined for mental and substance abuse.	Not applicable. All PEEHIP Certified Community Mental Health Centers are in-network.
Outpatient Physician Services for Blue Choice Behavioral Network Providers	Covered at 100% of the allowed amount, subject to a $50 copay per visit. Limited to 12 visits per member each plan year for in-network; deductible does not apply and no balance billing when using a Blue Choice Behavioral Network provider. Maximum visits are combined for mental and substance abuse. For a list of in-network Blue Choice Behavioral Health Network providers, see **AlabamaBlue.com**.	Covered at 50% of the allowed amount, subject to the calendar year deductible; limited to a maximum of 10 visits per member per plan year for out-of-network. Maximum visits are combined for mental and substance abuse.

PRESCRIPTION DRUG BENEFITS
(PRESCRIPTION DRUG BENEFITS PROVIDED THROUGH MEDIMPACT)

Prior Authorization, Step Therapy and/or Quantity Limits may apply for some drugs.

	Up to a 30 day supply	31 – 60 day supply	61 – 90 day supply
Tier 1 – Generic Drugs	**$6**	**$12**	**$12**
Tier 2 – Preferred Brand Drugs	**$40**	**$80**	**$120**
Tier 3 – Non-preferred Brand Drugs	**$60**	**$120**	**$180**
Specialty Drugs	**20% coinsurance per prescription, with a minimum of $100 copay and maximum of $150 copay**	**Days supplies greater than 30 are not allowed for specialty drugs**	**Days supplies greater than 30 are not allowed for specialty drugs**

Generic Law: Pharmacists must dispense a generic equivalent medication when one is available unless the physician indicates in longhand writing on the prescription, indicates by mark or signature in the appropriate place on the prescription, or indicates in an electronic prescription the following: "medically necessary" "dispense as written," or "do not substitute." The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent, contain the same active ingredient or ingredients, and shall be of the same dosage form and strength.

Maintenance Drugs: To obtain a supply greater than 30 days, the drug must be on PEEHIP's Maintenance Drug List and must be prescribed for up to a 90 days supply. The first fill of a maintenance drug will be a 30 day supply. Subsequent fills can be obtained up to a 90 days supply.

Dispense as Written (DAW) Cost Differential: Members will be subject to the difference between the cost of the brand drug and its generic equivalent, regardless of whether the physician indicates the brand must be taken.

Diabetic Supplies: Diabetic supplies are covered only through the pharmacy drug plan.

Certain prescription drugs are excluded from PEEHIP coverage. To verify the drug formulary coverage status of a medication, please visit the MedImpact website at https://mp.medimpact.com/ala

Non-participating pharmacies (both in-state and out-of-state): Members must pay the full amount of the prescription drug and then file the claim to MedImpact to be reimbursed at the participating pharmacy rate less the applicable copay. All PEEHIP clinical utilization management programs will apply. Out-of-pocket costs will be higher if you use a non-participating pharmacy.

Contraceptives: Generic contraceptive drugs are covered at a zero copay. Brand contraceptives are covered at the applicable brand copay.

Flu vaccines: Flu vaccines are covered at a zero copay when administered by a participating pharmacy.

Shingrex vaccine: Covered at zero copay when administered by a participating pharmacy for those aged 50 and older.

Specialty Drugs – Copay Assistance Programs: Copays for certain specialty medications may vary and be set to the maximum of any available manufacturer-funded copay assistance programs. PEEHIP and MedImpact will offer copay assistance programs for certain specialty drugs so that the member copayment will normally be less than the otherwise applicable copayment.

Infertility Drugs: Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP member contract. Members will pay 100% of the cost of the medications after the $2,500 lifetime maximum is reached.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
BENEFITS FOR OTHER COVERED SERVICES		
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 the calendar year deductible	Covered at 80% of the allowed amount subject to the calendar year deductible.
Ambulance Service	Covered at 80% of the allowed amount subject to the calendar year deductible	Covered at 80% of the allowed amount subject to the calendar year deductible.
Participating Chiropractic Services	Covered at 80% of the allowed amount; no copay or deductible **Note:** In Alabama, more than 15 visits in a calendar year rendered by a Participating Chiropractor require precertification.	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 12 visits in a calendar year.
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Physical Therapy Physical therapy will require precertification after 15 visits to determine medical necessity for continued therapy. Call 1-800-354-7412	Covered at 80% of the allowed amount subject to the calendar year deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible.
Occupational Hand Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to certain services related to the hand and lymphedema.
Speech Therapy	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network.	Covered at 80% of the allowed amount subject to the calendar year deductible. Limited to 30 sessions per person per calendar year combined in and out-of-network.
Applied Behavioral Analysis (ABA) Therapy for children aged 0-18 diagnosed with an Autism Spectrum Disorders Annual dollar maximums are combined for both in and out-of-network	Covered at 100% of the allowed amount subject to a $15 copay per visit and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.	Covered at 100% of the allowed amount subject to a $15 copay per visit and the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 *Preauthorization* is required prior to rendering ABA therapy to determine the medical necessity. *Preauthorization* is also required every six months thereafter to determine the medical necessity for continued therapy. If preauthorization is not obtained, coverage for all services associated with subsequent visits will be denied.
Preferred Home Health and Hospice	Covered at 100% of the allowed amount; no copay or deductible. Precertification required for services rendered outside of Alabama. Call 1-800-248-2342	Covered at 80% of the allowed amount subject to the calendar year deductible. Precertification required for services rendered outside of Alabama. Call 1-800-248-2342 **In Alabama,** out-of-network facilities, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Infertility Testing and Treatment Limited to a lifetime maximum of 8 artificial insemination attempts (whether successful or not). Benefits are not provided for IVF (in-vitro fertilization), ART or GIFT (gamete intrafallopian transfer).	Covered at 100% of the allowed amount; no copay or deductible.	Covered at 80% of the allowed amount subject to the calendar year deductible.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease. Disease Management is provided by ActiveHealth for subscribers and covered spouses. For more information, call 1-855-294-6580. Disease Management is provided by Blue Cross and Blue Shield of Alabama for children and adult child dependents. For more information, call 1-888-841-5741.	
Baby Yourself®	A maternity program highly recommended for all pregnancies; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com.** This group will waive the in-network and out-of-network inpatient hospital $200 per admission copayment for maternity admissions for the delivery of a baby for members participating in Baby Yourself. The member must enroll in the program in the first trimester and complete the program. The $25 per day copay will still apply for days 2-5, if applicable.	

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.*
- *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.*
- *Teladoc® is an independent company providing phone and online physician consultation services to Blue Cross and Blue Shield of Alabama members.*

Please note: Providers/Specialists may be listed in a PPO directory or on the provider finder website (**www.bcbs.com**), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or benefit booklet to determine coverage.
This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract.
Check your benefit booklet for more detailed coverage information.
PEEHIP members who use non-participating hospitals, providers or outpatient facilities will incur additional out-of-pocket costs.
To maximize your benefits, always use network providers.
Teladoc® is an independent company providing phone and online physician consultation services to Blue Cross and Blue Shield of Alabama members.
If you have any questions concerning your PEEHIP hospital / medical benefits or a claim, call 1-800-327-3994.
To certify emergency or maternity admission, call 1-800-354-7412.
To certify home health and hospice services, call 1-800-821-7231.
To take advantage of the Baby Yourself® program, call 1-800-222-4379.
Visit our website at **AlabamaBlue.com/peehip**
For questions concerning prescription drugs, call MedImpact at 1-877-606-0727.
https://mp.medimpact.com/ala **G**roup 14000 Revised 10-02-2018 afr

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama 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。