

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.rsa-al.gov](http://www.rsa-al.gov). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.bcbsal.org/sbcglossary/](http://www.bcbsal.org/sbcglossary/) or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$300 individual/\$900 family	Generally, you must pay all costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care in-network</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$200 per admission. \$200 per admission for <a href="#">out-of-network</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$400 individual per calendar year for Major Medical Services; For <a href="#">in-network</a> , there is also an overall calendar year <a href="#">out-of-pocket limit</a> of \$8,150 individual / \$16,300 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, health care this <a href="#">plan</a> does not cover, <a href="#">out-of-network coinsurance</a> , pre-certification penalties, and <a href="#">coinsurance</a> for outpatient mental health and substance abuse.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://AlabamaBlue.com">AlabamaBlue.com</a> or call 1-800-810-BLUE for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> / visit No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	\$5 copay for laboratory or pathology per test for <a href="#">in-network</a> may apply; Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network provider</a>  Visit <a href="#">AlabamaBlue.com/preventiveservices</a> ; additional services are available. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your provider if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> / visit No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge No overall <a href="#">deductible</a>	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Benefits listed are physician services; facility services are also available; <a href="#">precertification</a> may be required; \$5 <a href="#">copay</a> for laboratory or pathology per test for <a href="#">in-network</a> may apply; subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a> .
	Imaging (CT/PET scans, MRIs)	No charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://mp.medimpact.com/ala">https://mp.medimpact.com/ala</a> .	Generic drugs (Tier 1)	\$6 <a href="#">copay</a> /prescription days 1-30 \$12 <a href="#">copay</a> /days 31-60 \$12 <a href="#">copay</a> /days 61-90	Same <a href="#">copays</a> as <a href="#">in-network</a> , but you must pay <a href="#">out-of-pocket</a> and submit a paper claim for reimbursement. The <a href="#">plan</a> will reimburse you based on the allowed amount for <a href="#">in-network</a> pharmacies.	Covers up to a 30-day supply or 90-day supply for approved maintenance medications. Certain drugs may require <a href="#">prior authorization</a> for the <a href="#">plan</a> to pay. Generic equivalent drugs mandatory when available.
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> /prescription days 1-30 \$80 <a href="#">copay</a> /days 31-60 \$120 <a href="#">copay</a> /days 61-90		
	Non-preferred brand drugs (Tier 3)	\$60 <a href="#">copay</a> /prescription days 1-30 \$120 <a href="#">copay</a> /days 31-60 \$180 <a href="#">copay</a> /days 61-90		
	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance</a> \$100 <a href="#">copay</a> (minimum) \$150 <a href="#">copay</a> (maximum)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> /service No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a> ; in Alabama, <a href="#">out-of-network</a> not covered
	Physician/surgeon fees	No charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a>
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /facility per visit & \$35 <a href="#">copay</a> /physician per visit	\$150 <a href="#">copay</a> /facility per visit & \$35 <a href="#">copay</a> /physician per visit	Benefits are for medical emergencies and treatment of accidental injuries if treated within 72 hours; Facility and Physician charges for treatment of accidental injuries treated after 72 hours covered at 80% of the allowed amount subject to calendar year <a href="#">deductible</a> ; Facility and Physician services for non-medical emergencies covered at 80% of the allowed amount subject to calendar year <a href="#">deductible</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Subject to overall <a href="#">deductible</a>
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a>
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <a href="#">deductible</a> /admission & \$25 <a href="#">copay</a> /day for days 2-5	\$200 <a href="#">deductible</a> /admission & \$25 <a href="#">copay</a> /day for days 2-5 & 20% <a href="#">coinsurance</a>	Subject to \$200 <a href="#">deductible</a> /admission and \$25 <a href="#">copay</a> /day for days 2-5 for <a href="#">in-network</a> facilities and <a href="#">out-of-network</a> facilities outside Alabama; in Alabama, <a href="#">out-of-network</a> benefits are only available for accidental injury; <a href="#">precertification</a> is required for coverage
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> /visit for up to 12 visits per year; <a href="#">deductible</a> does not apply and no balance billing when using a Blue Choice Behavioral Network <a href="#">provider</a> . Maximum visits are combined for mental and substance abuse.	Physician Services: 50% <a href="#">coinsurance</a> , subject to the overall <a href="#">deductible</a> ; limited to a maximum of 10 visits per member per plan year for <a href="#">out-of-network</a> . Maximum visits are combined for mental and substance abuse.	For a list of <a href="#">in-network</a> Blue Choice Behavioral Health Network <a href="#">providers</a> , see <a href="http://www.AlabamaBlue.com">www.AlabamaBlue.com</a> . Certified Community Mental Health Centers are <a href="#">in-network</a> ; \$10 <a href="#">copay</a> /visit limited to 20 visits per member per plan year for <a href="#">in-network</a> . Maximum visits are combined for mental and substance abuse.
	Inpatient services	Facility Services: No charge/days 1-9 \$15 <a href="#">copay</a> /days 10-14 \$20 <a href="#">copay</a> /days 15-19 \$25 <a href="#">copay</a> /days 20-24 \$30 <a href="#">copay</a> /days 25-30  Physician Services: 20% <a href="#">coinsurance</a> , subject to overall <a href="#">deductible</a>	Facility Services: \$200 <a href="#">deductible</a> /admission & \$25 <a href="#">copay</a> /day for days 2-5  Physician Services: 20% <a href="#">coinsurance</a> , subject to the overall <a href="#">deductible</a>	Benefits listed are for facility services; physician services covered at 80% subject to overall <a href="#">deductible</a> ; Limited to maximum of 30 days per member per plan year; <a href="#">Out-of-network</a> is only available for short term crisis intervention and until member is stable enough to be moved to PPO Hospital; <a href="#">Precertification</a> is required for coverage. Inpatient Substance Abuse limited to one admission per plan year and maximum of two admissions per lifetime.
If you are pregnant	Office visits	No charge. No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge. No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$200 <a href="#">deductible</a> /admission & \$25 <a href="#">copay</a> /day beginning with the 2 <sup>nd</sup> through the 5 <sup>th</sup> day No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , subject to \$200 <a href="#">deductible</a> /admission & \$25 <a href="#">copay</a> /day beginning with the 2 <sup>nd</sup> through the 5 <sup>th</sup> day	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , subject to the overall <a href="#">deductible</a>	Subject to overall <a href="#">deductible</a> for <a href="#">out-of-network</a> outside of Alabama; <a href="#">precertification</a> may be required. <a href="#">Out-of-network</a> not covered within the state of Alabama

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay)		
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> ; subject to the overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> ; subject to the overall <a href="#">deductible</a>	Subject to overall <a href="#">deductible</a> ; occupational therapy is limited to certain services related to hand and lymphedema; speech therapy is limited to a maximum of 30 visits per member per calendar year.	
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> ; subject to the overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> ; subject to the overall <a href="#">deductible</a>		
	<a href="#">Skilled nursing care</a>	Not covered	Not covered		Not covered; member pays 100%
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> , subject to overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , subject to overall <a href="#">deductible</a>		<a href="#">Out-of-network</a> , member responsible for any difference between the charge and the allowed amount
	<a href="#">Hospice services</a>	No charge No overall <a href="#">deductible</a>	20% <a href="#">coinsurance</a> , subject to the overall <a href="#">deductible</a>		In Alabama, <a href="#">out-of-network</a> not covered; <a href="#">precertification</a> may be required.
If your child needs dental or eye care	Children's eye exam	No charge No overall <a href="#">deductible</a>	Not covered	Benefits listed are mandated <a href="#">preventive</a> services; visit <a href="#">AlabamaBlue.com/preventiveservices</a> ; additional benefits are available; limitations apply	
	Children's glasses	Not covered No overall <a href="#">deductible</a>	Not covered	Not covered; member pays 100%	
	Children's dental check-up	No charge No overall <a href="#">deductible</a>	Not covered	Benefits listed are mandated <a href="#">preventive</a> services; visit <a href="#">AlabamaBlue.com/preventiveservices</a> ; additional benefits are available; limitations apply	

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Glasses, child
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery (Only morbid obesity in limited circumstances)
- Chiropractic care (Limited to 12 visits per member per calendar year for [out-of-network](#))
- Infertility treatment (Limitations apply)
- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Alabama at 1-800-327-3994.

#### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copay/coinsurance</a>	\$35/0%
■ Hospital (facility)	
<a href="#">copay/coinsurance</a>	\$25/0%
■ Other <a href="#">copay/coinsurance</a>	\$40/20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$250
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$310</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copay/coinsurance</a>	\$35/0%
■ Hospital (facility)	
<a href="#">copay/coinsurance</a>	\$25/0%
■ Other <a href="#">copay/coinsurance</a>	\$40/20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$40
Coinsurance	\$60

What isn't covered	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$400</b>
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### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copay/coinsurance</a>	\$35/0%
■ Hospital (facility)	
<a href="#">copay/coinsurance</a>	\$25/0%
■ Other <a href="#">copay/coinsurance</a>	\$40/20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$20
Copayments	\$380
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$420

<b>The total Joe would pay is</b>	<b>\$820</b>
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Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.rsa-al.gov/index.php/members/PEEHIP](http://www.rsa-al.gov/index.php/members/PEEHIP).

## Language Access Services and Notice of Nondiscrimination:

The Public Education Employees' Health Insurance Plan (PEEHIP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEEHIP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PEEHIP:

- 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, or other formats); and
- 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, at 1-877-517-0020. If you believe that PEEHIP has 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 with: Public Education Employees' Health Insurance Plan, 201 South Union Street, Montgomery, Alabama, 36104, Attn: 1557 Compliance Coordinator, 1-877-517-0020, 1-877-517-0021 (fax), PEEHIP.Info@rsa-al.gov (email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Section 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>.

## Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-517-0020.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-517-0020 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1-877-517-0020。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-517-0020.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية نتوانر لك بالمجان. انصل برؤم: 1-877-517-0020-1 Arabic:

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-517-0020.



French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-517-0020.

Gujarati: ધ્યાન દે: જો તમે ગજરાતી બોલતા હો, તો ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-877-517-0020.  
નિશ્ચ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-517-0020.

Hindi: ध्यान दे: यदि आप हिंदी बोलते हैं तो आपको बिलकुल मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-517-0020 पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-517-0020.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-517-0020.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-517-0020.

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-517-0020 irtibat numaralarını arayın.

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。1-877-517-0020 まで、お電話にてご連絡ください。