





Plan Benefits

BlueCard® PPO

Auburn University

PPO Copay Plan

BlueCard® PPO

Effective January 1, 2027

Visit our website:

AlabamaBlue.com

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Auburn University
PPO Copay Plan- BlueCard PPO
January 1, 2027

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received. Some services require a copay, coinsurance or calendar year deductible for each visit or service.		
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.		
Calendar Year Deductible	$500 per person each calendar year; 3-member family maximum. 4th Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which may have been allocated toward all **or** a portion of the Calendar Year Deductible for that year may also be allocated toward next year's Calendar Year Deductible.	
Calendar Year Out-of-Pocket Maximum	$12,000 individual (including the calendar year deductible) $24,000 family (including the calendar year deductible) Deductibles, copays and coinsurance for in-network services and out-of-network mental health and substance abuse emergency services apply to the in-network out-of-pocket maximum; payments made by drug manufacturer assistance programs may not apply towards the deductible or out-of-pocket maximum. 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.	There is no out-of-pocket maximum for out-of-network services.
Cancer Treatment (Facility and Physician)	Covered at 100% of the allowed amount; no copay or deductible	
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal law); notification is required 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 and Residential Treatment Facilities (including maternity)	Covered at 100% of the allowed amount after $300 per admission facility copay and calendar year deductible	Covered at 80% of the allowed amount after $300 per admission facility copay and calendar year deductible **Note**: In Alabama, 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	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 80% of the allowed amount, no copay or deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for provider-administer drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers) Colonoscopy with family history of colon cancer covered at 100%, no copay or deductible	Covered at 100% of the allowed amount after $300 per visit facility copay and calendar year deductible.	Covered at 80% of the allowed amount after $300 per visit facility copay and calendar year deductible. **In Alabama**: Not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount after $300 per visit facility copay and calendar year deductible.	Covered at 100% of the allowed amount after $300 per visit facility copay and in-network calendar year deductible.
Emergency Room (Accident)	Covered at 100% of the allowed amount after $300 per visit facility copay and calendar year deductible.	Covered at 100% of the allowed amount after $300 per visit facility copay and in-network calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Physician	Covered at 100% of the allowed amount subject to the $50 per visit physician copay and calendar year deductible.	Covered at 100% of the allowed amount subject to the $50 per visit physician copay and in-network calendar year deductible.
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy (including oncology medical specialty drugs), Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible.	Covered at 80% of the allowed amount subject to calendar year deductible. **In Alabama**: Not covered
IV Therapy (medical specialty drugs other than oncology)	Covered at 70% of allowed amount, maximum member cost share $250 and subject to calendar year deductible	Covered at 70% of allowed amount, maximum member cost share $250 and 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 100% of the allowed amount, after $40 daily hospital copay	Covered at 80% 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 provider-administer drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Office Visits & Consultations **Benefits are provided for treatment of ADD and ADHD when services are rendered by a Pediatrician and Primary Care Physician**	Covered at 100% of the allowed amount subject to $30 per visit primary physician copay or $40 per visit specialist physician copay	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Urgent Care	Covered at 100% of the allowed amount subject to $30 per visit physician copay	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia Colonoscopy with family history of colon cancer covered at 100%, no copay or deductible	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to 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 calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy (including oncology medical specialty drugs), Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 80% of the allowed amount subject to calendar year deductible **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible
IV Therapy (outpatient setting or office visit setting for administration of medical specialty drugs other than oncology)	Covered at 70% of the allowed amount subject to calendar year deductible up to a maximum member responsibility of $250 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. The $250 maximum only applies to medical specialty drugs not included in the HealthSmartRx program.	Covered at 70% of the allowed amount subject to calendar year deductible up to a maximum member responsibility of $250 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. The $250 maximum only applies to medical specialty drugs not included in the HealthSmartRx program. **In Alabama,** covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Applied Behavioral Analysis (ABA) Therapy Limited to ages 0-18 for autism spectrum disorders	Covered at 100% of the allowed amount subject to $30 copay	Covered at 80% of the allowed amount subject to calendar year deductible
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/preventiveservices** and **AlabamaBlue.com/StandardACAPreventive DrugList** for a listing of the specific 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. In addition to the standard benefits, the following is covered: Colonoscopy with family history of colon cancer covered at 100%, no copay or deductible (not subject to regular ACA limits)	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.		
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for provider-administer drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/HelpScript, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Allergy Testing & Treatment	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Ambulance Service	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to in-network calendar year deductible
Chiropractic Services	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible In Alabama, covered at 50% of the allowed amount, subject to the calendar year deductible
Durable Medical Equipment (DME)	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Rehabilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Habilitative Occupational, Physical and Speech Therapy Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders ages 0-18 with a diagnosis of autism meeting certain clinical criteria	Covered at 70% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount subject to calendar year deductible
Home Health and Hospice **Precertification is required for Skilled Nursing visits when rendered by a provider outside the State of Alabama. Call 1-800-821-7231.**	Covered at 100% of the allowed amount subject to calendar year deductible.	Covered at 70% of the allowed amount, subject to calendar year deductible In Alabama, not covered
Home Infusion Services	Covered at 70% of the allowed amount subject to calendar year deductible.	Covered at 70% of the allowed amount, subject to calendar year deductible In Alabama, not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disoders and Substance Abuse)		
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.		
Prescription Drug Card • Prescription medications can be filled with up to a 30 day supply at retail at one time. The designated copayment for the medication's tier is due with each fill. • The pharmacy network for the plan is Prime Participating Network Locate a Prime Participating Network pharmacy at **AlabamaBlue.com/Prime ParticipatingPharmacyLocator** • View the **Standard Prescription Drug** list that applies to the plan at **AlabamaBlue.com/StandardDrugList** • Retail pharmacy benefits are available for prescription drugs up to a 90 day supply with two copays when purchased at the Auburn University Employee Pharmacy. • AU maintains a list of select medications that are considered maintenance medications. (Note: This list does not include all chronic medications.) These medications are used to treat chronic disease and are often stabilized at treatment doses. For medications on this list, the first fill is limited to a 30 day supply (this includes when the medication is first started, re-started after a lapse in therapy, or the dosage is adjusted). After 30 days of treatment, if the prescriber is comfortable that the medication is effective, well tolerated and dosed optimally, then the prescriber has the option to write for up to a 90 day supply, and the patient will only be responsible for two copays instead of three when purchased through pharmacies participating in the extended supply pharmacy network (ESN Network). View the maintenance drug list that applies to the plan at **AlabamaBlue.com/ MaintenanceDrugList** • AU offers a pharmacy benefit where a beneficiary can elect to participate in a voluntary pill-splitting program for cholesterol-lowering medications called "statins". Through this program if the prescriber writes for half a tablet of a higher strength medication instead of a whole tablet of a lower strength medication, then the patient will pay a half co-pay (for 17 tabs for a 34 day supply and one copay for 45 tabs for a 90 day supply). For the 90-day supply, the statin must be on the AU approved maintenance drug list. • Specialty drugs can be dispensed for up to a 30-day supply. They can be filled at the **AU Employee Pharmacy** (334-844-8938 or tigermeds@auburn.edu). View the Specialty Drug Lists at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** and **AlabamaBlue.com/ProviderAdministeredSpecialtyDrugList** • Certain drugs are part of the FlexAccess Program. See list at **AlabamaBlue.com/FlexAccessDrugList** • AU offers a manufacturer's coupon assistance program for specific drugs. The FlexAccess Program will apply to **AU Employee Pharmacy** (334-844-8938 or tigermeds@auburn.edu). So long as the manufacturer's coupon exist, if the member is eligible for a manufacturer's coupon, the coupon shall be used to pay the member's plan copay • **Diabetic Supplies (**copays apply) are covered only through the Prescription Drug Card Program**.** Some copays might be combined.	**Participating Pharmacy (In Network)**: Covered at 100% of the allowed amount, subject to the following copays per prescription: **No Copay ($0):** Certain prescription medications that are used for contraception and for smoking cessation will have no copay at network pharmacies **Tier 1 Medications:** • $0 through the TigerMeds Program (see below) • $15 copay per prescription at all in-network pharmacies • $30 copay per prescription at non-preferred pharmacies* **Tier 2 Medications:** • $10 through the TigerMeds Program (see below) • $25 copay per prescription at all in-network pharmacies • $40 copay per prescription at non-preferred pharmacies* **Tier 3 Medications:** • $55 copay per prescription at all in-network pharmacies • $70 copay per prescription at non-preferred pharmacies* **Tier 4 Medications:** • $85 copay per prescription at all in-network pharmacies • $100 copay per prescription at non-preferred pharmacies* **Tier 5 Medications:** 25% coinsurance up to a maximum of $800 per prescription at preferred and non-preferred pharmacies * For drugs on the FlexAccess Drug List, cost share may vary based on available drug manufacturer assistance. If assistance is available, the amount member pays out-of-pocket will be set by the drug manufacturer assistance program. • The TigerMeds program is an employee benefit offered to employees and family members who subscribe to the AU Health Insurance Plan. It is offered exclusively through AU's Employee Pharmacy. To enroll in TigerMeds, beneficiaries must complete a baseline medication therapy management (MTM) (medication check-up) appointment with a pharmacist, and must transfer all prescription medications to the AU Employee Pharmacy (not a partial list; must transfer all meds). Once enrolled in TigerMeds, the beneficiary receives generic Tier 1 medications at no copay ($0), and Tier 2 at $10 copay per prescription. Patients are also eligible for free on-campus and local delivery, free refill reminders, remote pharmacy consultations, etc. (334) 844-8938 or tigermeds@auburn.edu. • Medication Tiers are subject to change. To look up the tier of a specific medication visit AlabamaBlue.com/StandardDrugList	**Non-Participating Pharmacy in Alabama:** No benefits are available for prescriptions purchased in a non-Participating Pharmacy in Alabama. Non-covered. **Non-Participating Pharmacy Outside Alabama:** Covered at 100% of the allowed amount subject to the in-network copays (see column to left). In addition, the member will be responsible for any difference between the allowance and the actual billed charge. (**Note:** The amount paid for the difference between the allowance and the actual billed charge does not apply to the in-network out-of-pocket maximum.)

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
• There have been several medications excluded from the AU prescription plan this year, and some medications have changed tiers. Support is available for any beneficiary who has experienced a change in prescription drug coverage or cost in prescription medications. Individual medication consultations are available through the Auburn University Pharmaceutical Care Center (AUPCC). Call 334-844-4099 or e-mail aupcc4u@auburn.edu to schedule an appointment. For more information about the AUPCC- See: http://www.auburn.edu/academic/pharmacy/phs/clinic/employee.html • Oral prescription medications used to treat impotence, erectile dysfunction, sexual dysfunction (in men or women) is not covered by the AU prescription plan. Sildanefil (generic Viagra®) is covered with a PA when medical necessity is demonstrated for other disease states such as pulmonary artery hypertension (PAH). • Prescription Proton Pump Inhibitors (PPIs) will be restricted to generic omeprazole, generic pantoprazole, and generic lansoprazole (all Tier 1). No step therapy will be required. Many PPIs that were historically only available with a prescription are now available over-the-counter (OTC). Prevacid Solutabs® ODT tablets are available only with a PA demonstrating medical need. (Tier 4 - $80 copayment or $95 copayment at a non-preferred pharmacy - per prescription, when approved). • Prescription nasal steroids will be restricted to generic fluticasone only (Tier 1). Prescription strength nasal steroids are available over the counter (OTC) without a prescription. Medication information and assistance with OTC selections are available through the AU Employee Pharmacy (tigermeds@auburn.edu). • Infertility limited to oral medications only. No injectable fertility medications are covered. • The AUPCC offers a "TigerMeds Cholesterol" program. Beneficiaries who take certain brand name cholesterol medications might be invited to participate in this employee benefit program. The TigerMeds Cholesterol program focuses on providing quality, individualized care by a team of healthcare professionals to ensure optimal outcomes of medication use----and also the potential to save the beneficiary money in out-of-pocket medication costs. The AUPCC also has diabetes management, asthma, COPD, congestive heart failure, and smoking cessation programs. Call 334-844-4099 for more information. Employee incentives are provided for qualifying patients who participate in these programs in the AUPCC. • The AU Employee Pharmacy (AUEP) is proud to serve as a local resource for specialty medications, drug information and medication monitoring. Please call the AU Employee Pharmacy at (334) 844-4938 or e-mail tigermeds@auburn.edu for more information. • The AU Employee Pharmacy provides 24 hour/7 days a week access to a pharmacist. You or your physician can access the on-call pharmacist by calling 334-750-1048. The on-call pharmacist will assist you with medication filling during medication emergencies.	• *Non-preferred pharmacies: CVS owned and operated pharmacies, such as, CVS pharmacy and Target pharmacy. • AU strictly enforces a mandatory generic policy. If a generic is available for a brand name medication, then the generic must be dispensed. The only exception to this policy is a short list of narrow therapeutic drugs (NTD) that might be prescribed brand name by a physician if brand is deemed necessary. **In all other situations**, if a brand name of a medication is requested for a medication where there is a generic available (regardless if the request comes from the doctor or the patient), the medication will be non-covered and the patient will be responsible for all costs. The only exception is for the NTI override list. • A limited number of medications used for chronic diseases at stable doses are classified as "maintenance medications" on our plan. This list does not include all chronic medications. If a prescriber considers a treatment (drug and dose) as stable and wishes to write for a 90-day supply, then the subscriber can get a 90 day supply for two copayments instead of three. All Tier 4 and Tier 5 chronic maintenance medications are excluded from the maintenance medication program. • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/ VaccineNetworkDrugList** for more information **For more information on AU's pharmacy benefit, please refer to your Benefit Booklet**	

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 and chronic obstructive pulmonary disease and other specialized conditions.	
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.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at **AlabamaBlue.com/BabyYourself**. Auburn University will waive the $300 inpatient hospital copay and calendar year deductible (or remainder of deductible at time of admission) for the maternity benefit only for covered members, spouses and dependents who enroll in Baby Yourself® during the first 16 weeks of pregnancy.	

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 Blue Cross and Blue Shield of Alabama or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD, Preferred Care).*
- *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 Blue Shield of Alabama or another Blue Cross and /or Blue Shield Plan. 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 or in accordance with applicable Federal Law.*
- *Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.*

This is not a contract, benefit booklet or a 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.

Group #37655 (pharmacy benefits are excluded from divisions 15R and 16R)
10/16/2026 GMD

Notice of Nondiscrimination

Discrimination is Against the Law

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 (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary 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 assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.ى

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese:
ご案内：日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.