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# Local Government Health Insurance Plan Benefit Summary



Effective January 1, 2024



An Independent Licensee of the Blue Cross and Blue Shield Association

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## Local Government Health Insurance Plan JANUARY 1, 2024

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard® Preferred Provider Organization (PPO) Program. To find out if your provider is a PPO member, call 1-800-810-BLUE (2583) or access the Blue Cross website, [AlabamaBlue.com](http://AlabamaBlue.com). Please be aware that not all providers participating in the BlueCard® PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in the "Benefit Conditions" section of the Plan book.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>INPATIENT HOSPITAL BENEFITS</b>		
Precertification is required for inpatient admissions (except medical emergency, maternity and as required by Federal law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 for precertification.		
<b>Inpatient Facility Coverage (including maternity)</b>	Covered at 100% of the allowance, subject to a \$200 per admission deductible and \$50 copay per day for days 2-5	Covered at 80% of the allowance, subject to a \$200 per admission deductible and \$50 copay per day for days 2-5.
<b>OUTPATIENT HOSPITAL BENEFITS</b>		
Precertification is required for certain outpatient hospital benefits, including radiology services and a select group of provider-administered drugs; visit <a href="http://AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList">AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList</a> . Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
<b>Surgery</b>	Covered at 100% of the allowance, subject to the \$100 facility copay. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.
<b>Medical Emergency</b>	Covered at 100% of the allowance, subject to the \$200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical. Includes Mental Health Disorders and Substance Abuse services.	Covered at 100% of the allowance, subject to the \$200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical. Includes Mental Health Disorders and Substance Abuse services.
<b>Accidental Injury</b>	Covered at 100% of the allowance with no deductible or copay	Covered at 100% of the allowance with no deductible or copay
<b>Diagnostic X-rays &amp; Tests</b>	Covered at 100% of the allowance, subject to the \$100 facility copay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Diagnostic Lab &amp; Pathology</b> Certain outpatient x-rays and tests require precertification, call 1-866-803-8002.	Covered at 100% of the allowance, subject to a \$7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Dialysis, IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 100% of the allowance, subject to the \$25 facility copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Note:</b> In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
<b>PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS</b>		
Precertification is required for a select group of provider-administered drugs; visit <a href="http://AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList">AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList</a> . Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on <a href="http://AlabamaBlue.com/Providers/HealthSmartRx">AlabamaBlue.com/Providers/HealthSmartRx</a> , cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
<b>Primary Care Physician Office Visits, Office Surgery &amp; Outpatient Consultations</b>	Covered at 100% of the allowance, subject to the \$40 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Specialist Physician Office Visits, Office Surgery &amp; Outpatient Consultations</b>	Covered at 100% of the allowance, subject to the \$50 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Registered Dietician, Licensed Professional Counselor, Office Surgery &amp; Outpatient Consultations</b>	Covered at 100% of the allowance, subject to the \$20 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Physician fees for Outpatient Surgery and Anesthesia (other than in a physician's office)</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Second Surgical Opinion</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>Telephone and Online Video Consultations Program</b> A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone and online video consultations are available 24 hours a day, 7 days a week. To enroll go to <a href="http://Teladoc.com/Alabama">Teladoc.com/Alabama</a> or call 1-855-477-4549.	Covered at 100% of the allowance; no copay or deductible	Not covered.
<b>Emergency Room</b>	Covered at 100% of the allowance, subject to the office visit copay. Includes Mental Health Disorders and Substance Abuse services.	Covered at 100% of the allowance, subject to the office visit copay. Includes Mental Health Disorders and Substance Abuse services.
<b>Inpatient Visits</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Maternity</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Lab &amp; Pathology Exams</b>	Covered at 100% of the allowance, subject to a \$7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Diagnostic X-rays &amp; Tests</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>TELEHEALTH SERVICES</b>		
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.		
<b>ROUTINE PREVENTIVE CARE</b>		
<b>Routine Immunizations and Preventive Services</b>	Covered at 100% of the allowance with no deductible or copay. <ul style="list-style-type: none"> <li>See <a href="http://AlabamaBlue.com/preventiveservices">AlabamaBlue.com/preventiveservices</a> for a listing of the immunizations and preventive services or call the BCBS Customer Service Department at 1-800-321-4391 for a printed copy</li> </ul>	Covered at 80% of the allowance subject to the calendar year deductible. <ul style="list-style-type: none"> <li>See <a href="http://AlabamaBlue.com/preventiveservices">AlabamaBlue.com/preventiveservices</a> for a listing of the immunizations and preventive services or call Customer Service Department at 1-800-321-4391 for a printed copy</li> </ul>
<b>Additional Routine Preventive Services</b>	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: <ul style="list-style-type: none"> <li>Urinalysis (once by age 5, then once between ages 12-17)</li> <li>CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over)</li> <li>Glucose testing (once every calendar year age 18 and over)</li> <li>Cholesterol testing (once every calendar year age 18 and over)</li> <li>TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)</li> </ul>	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: <ul style="list-style-type: none"> <li>Urinalysis (once by age 5, then once between ages 12-17)</li> <li>CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over)</li> <li>Glucose testing (once every calendar year age 18 and over)</li> <li>Cholesterol testing (once every calendar year age 18 and over)</li> <li>TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)</li> </ul>
<b>MENTAL HEALTH DISORDERS SERVICES</b>		
<b>Inpatient Facility Services</b>	Covered at 100% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5. Precertification is required.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5. Precertification is required.
<b>Inpatient Provider Services</b>	Covered at 100% of the allowance, no copay or deductible.	Covered at 80% of the allowance no copay or deductible.
<b>LGHIP Outpatient Provider Services</b>  <b>(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)</b>	<b>Approved LGHIP Facilities:</b> Covered at 100% of the allowance with no deductible or copay. Other copays may apply based on services rendered. <b>Blue Choice Behavioral Network providers:</b> Covered at 100% of the allowance, subject to the applicable medical provider copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>Residential Treatment Facilities for treatment of Eating Disorders</b>	Covered at 100% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5; precertification and ongoing medical necessity review required.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5; precertification and ongoing medical necessity review required.
<b>Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders</b>	Covered at 100% of the allowance, subject to a \$100 copay per treatment episode. Precertification is required.	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required.
<b>SUBSTANCE ABUSE SERVICES</b>		
<b>Inpatient Facility Services</b>	Covered at 100% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5. Precertification is required.	Covered at 80% of the allowance, subject to a \$200 inpatient per admission deductible and \$50 copay per days 2-5. Precertification is required.
<b>Inpatient Provider Services</b>	Covered at 100% of the allowance; no copay or deductible.	Covered at 80% of the allowance.
<b>LGHIP Outpatient Provider Services</b>  (See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)	<b>Approved LGHIP Facilities:</b> Covered at 100% of the allowance, no copay or deductible. <b>Blue Choice Behavioral Network providers:</b> Covered at 100% of the allowance, subject to the applicable medical provider copay.	Covered at 80% of the allowance, subject to the calendar year deductible
<b>Intensive Outpatient Services and Partial Hospitalization for Substance Abuse Services</b>	Covered at 100% of the allowance, subject to a \$100 copay per treatment episode. Precertification is required.	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required.
<b>MAJOR MEDICAL GENERAL PROVISIONS</b>		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
<b>Calendar Year Deductible</b>	\$200 per person each calendar year; maximum of three deductibles per family.	
<b>Annual Out-of-Pocket Maximum</b>	<p>\$9,450 individual annual out-of-pocket maximum; \$18,900 family maximum.</p> <p><b>In-Network Services:</b> Deductibles, copays and coinsurance for in-network services and out-of-network emergency services apply to the out-of-pocket maximum, including prescription drugs. For members up to age 19, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum.</p> <p><b>Out-of-Network Services:</b> Do not apply to the out-of-pocket maximum.</p> <p>After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.</p>	
<b>MAJOR MEDICAL SERVICES</b>		
Precertification is required for certain major medical services and a select group of provider administered drugs; please see the Plan book for more information. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available. For provider-administered drugs listed on <a href="http://AlabamaBlue.com/Providers/HealthSmartRx">AlabamaBlue.com/Providers/HealthSmartRx</a> , cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
<b>Chiropractor Services</b>	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit.
<b>Applied Behavioral Analysis (ABA) Therapy</b>	<p>For children 18 years or younger, covered at 100% of the allowance after \$14 copay per visit.</p> <p>Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.</p>	<p>For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible.</p> <p>Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.</p>

<b>BENEFIT</b>	<b>IN-NETWORK (PPO)</b>	<b>OUT-OF-NETWORK (NON-PPO)</b>
<b>Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder</b>	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15 <sup>th</sup> visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15 <sup>th</sup> visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
<b>Rehabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy</b>	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15 <sup>th</sup> visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15 <sup>th</sup> visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
<b>Durable Medical Equipment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
<b>Ground Ambulance Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
<b>Air Ambulance Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
<b>Allergy Testing &amp; Treatment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
<b>Home Health Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required; call 1-800-821-7231.  In Alabama: No coverage for services rendered by a non-participating Home Health agency.
<b>Home Infusion Services</b>	Covered at 100% of the allowance, subject to the \$25 office visit copay when services are rendered by a participating Home Infusion Service Provider; Precertification is required for provider-administered drugs; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required for provider-administered drugs; call 1-800-821-7231.  In Alabama: No coverage for services rendered by a non-participating Home Infusion Service Provider.
<b>Diabetic Education</b>	Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-248-2342.	Not covered.
<b>Medical Nutrition Therapy</b> For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowance, subject to the applicable office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

#### **PRESCRIPTION DRUGS**

Prescription drug benefits are covered through OptumRx®. The plan utilizes the OptumRx Premium Formulary; however, plan benefits will supersede the Premium Formulary drug list. For more information, call OptumRx Member Services at 1 844-785-1603 or visit the website at [www.OptumRx.com](http://www.OptumRx.com).

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>TIER 1 DRUGS</b> <ul style="list-style-type: none"> <li>Generic non-maintenance drugs may be dispensed up to a 30-day supply.</li> <li>Generic maintenance drugs may be dispensed up to a 60-day supply, for one \$15 copay, after an initial 30-day supply fill.</li> <li>Specialty generic drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty generic drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.</li> </ul>	Covered at 100% of the allowance subject to a \$15 copay per prescription	No benefits are available for prescriptions purchased at a non-participating pharmacy.
<b>TIER 2 AND TIER 3 DRUGS</b> <ul style="list-style-type: none"> <li>Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90-day supply. Member must pay the cost of the drug and file a claim for reimbursement.</li> <li>The detailed prescription receipt, along with the register receipt, is required for reimbursement requests. See the Prescription Drugs Chapter in the Planbook for additional receipt requirements.</li> <li>Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.</li> </ul>	Covered at 80% of the allowance after being submitted for reimbursement. Subject to the calendar year deductible of \$200.	No benefits are available for prescriptions purchased at a non-participating pharmacy.
<b>TIER 4 DRUGS</b> <ul style="list-style-type: none"> <li>Brand drugs may be dispensed up to 90-day supply.</li> <li>Claims are not eligible for reimbursement.</li> <li>Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.</li> </ul>	Covered at 80% of the allowance; member is responsible for 20% coinsurance at the point of sale.	No benefits are available for prescriptions purchased at a non-participating pharmacy.

#### HEALTH MANAGEMENT BENEFITS

<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231 and press 7.
<b>Chronic Condition Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-833-964-1448 and press 0.
<b>Baby Yourself®</b>	A maternity program that will waive the hospital deductible and daily copays for inpatient admission at delivery. For the waived hospital deductible and daily copays to apply, the member must enroll in the Baby Yourself program within the first two trimesters of pregnancy. Members may enroll at <a href="http://AlabamaBlue.com/BabyYourself">AlabamaBlue.com/BabyYourself</a> . For more information, please call 1-800-222-4379.

**Note:** 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.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit the Local Government Health Insurance Board's website at [www.lghip.org](http://www.lghip.org).

The LGHIP is a self-insured health benefits plan administered by the LGHIB. The LGHIP provides minimum essential coverage and meets the minimum value standard as defined by the Affordable Care Act.

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. Please visit our website at [www.AlabamaBlue.com](http://www.AlabamaBlue.com).

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Group 30000  
Effective January 1, 2024

## 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](mailto: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 ed 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:** ໃບອຳນວຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຕະຫມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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。