BlueCross BlueShield of Alabama

We cover what matters.

Plan Benefits Summary

AlabamaBlue.com

Blue HSA Silver

FOR BUSINESS

Effective for plan years on and after January 1, 2024

Prescription Drugs: ValueONE Network

ValueONE Network Facts:

- 51,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Retail Network. This includes many national pharmacies you may already be using.
- 50,000 major national and regional pharmacy chains, retailers and grocers, and independent pharmacies participate in the ValueONE Extended Supply Network (ESN). This includes many national pharmacies you may already be using.
- Generally, ValueONE Retail Network pharmacies can fill up to a 30-day supply of retail drugs while ValueONE ESN Network pharmacies can fill up to a 90-day supply of certain medications (prescription must be written for up to a 90-day supply). Refer to your benefit booklet for the specific day supply permitted by your benefit plan. Since the type of pharmacy differs within the ValueONE Network, be sure to check your specific pharmacy.
- If you do not use a ValueONE Network pharmacy, you may be responsible for the full cost of your prescription medication. Benefits may not be provided for out-of-network pharmacies.
- To maximize your pharmacy benefits, you will need to transfer all your prescriptions to a ValueONE Network pharmacy.

Find a ValueONE Network Pharmacy
You can locate all of the participating pharmacies in your area at **AlabamaBlue.com/ValueONERetailPharmacyLocator.** Click on “Find a Pharmacy by Name or Location” located under Find a Pharmacy. When searching for a participating pharmacy, make sure either “ValueONE Retail Network” or “ValueONE ESN Network” is listed under “Network Participation” located to the right of the pharmacy address.

Blue HSA Silver for Business
High Deductible Health Plan – HSA Qualified
Effective for Plan Years on and after January 1, 2024
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.		
HEALTH SAVINGS ACCOUNT (HSA)		
A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.		
Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The **2024** maximum contribution is: **$4,150** for self-only coverage and **$8,300** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.		
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 The in-network and out-of-network calendar year deductibles are separate and do not apply to each other For family coverage, no benefits, except preventive care, are paid by the plan to any family member until the total medical expenses paid by the family equal the family deductible amount subject to the self-only calendar year out-of-pocket maximum.	**Self-Only coverage:** $4,000 **Family coverage:** $8,000	**Self-Only coverage:** $4,000 **Family coverage:** $8,000
Calendar Year Out-of-Pocket Maximum (including in-network calendar year deductible) Deductibles, copays and coinsurance for in-network services and out-of-network Mental Health Disorders and Substance Abuse emergency services apply to the out-of-pocket maximum	**Self-Only coverage:** $6,000 **Family coverage:** $12,000 After you reach your self-only Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), 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
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for inpatient admissions (except medical emergency services, maternity admissions 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 (toll-free) for precertification.		
Inpatient Hospital	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible **Note**: In Alabama, available only for medical emergency services and accidental injury
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some outpatient hospital benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Accident) **Note:** If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to **Emergency Room (Medical Emergency)** above.	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible when services are rendered within 72 hours of the accident; 50% of the allowed amount subject to 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 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Outpatient Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health and Substance Abuse	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some physician benefits. Precertification is also required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.		
Office Visits, Consultations & Psychotherapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Telephone and Online Video Physician Consultations Program To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-855-477-4549. Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical issues.	Covered at 0% of the allowed amount after $55 payment per consultation	Not covered
Second Surgical Opinion	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Surgery & Anesthesia	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Maternity Care	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Immunizations and Preventive Services • See **AlabamaBlue.com/PreventiveServices** and **AlabamaBlue.com/StandardACAPreventiveDrugList** for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy. • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. See **AlabamaBlue.com/VaccineNetworkDrugList** for more information.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
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.		
PEDIATRIC VISION BENEFITS		
Pediatric Eye Exam Limited to one exam (including refraction) per member per calendar year up to the end of the month in which the member turns 19.	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Pediatric Glasses or Contact Lenses Limited to one pair of prescription glasses per member per calendar year; contact lenses are limited to one 12-month supply per calendar year. Benefits are available up to the end of the month in which the member turns 19.	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some drugs; if no precertification is obtained, no benefits are available.		
Retail Prescription Prepaid Drug Benefits The retail pharmacy network for the plan is the **ValueONE Retail Network**. • Locate a ValueONE Network Pharmacy at **AlabamaBlue.com/ValueONERetailPharmacyLocator** Prescription drugs (other than maintenance prescription drugs) can be dispensed for up to a 30-day supply. • View the **Source+Rx 1.0 Drug** list that applies to the plan at **AlabamaBlue.com/2024SourcePlusRx1DrugList** Maintenance prescription drugs can be dispensed for up to a 30-day supply • View the Maintenance Drug List that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** • Some copays maybe combined for diabetic supplies Tier 5 and 6 (Specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some Tier 5 and 6 (Specialty) drugs is the **Pharmacy Select Network**. • View the Specialty Drug List that applies to the plan at **AlabamaBlue.com/SelfAdministeredSpecialtyDrugList** Some immunizations may be received from an in-network pharmacy that participates in the **Pharmacy Vaccine Network.** • A list of the eligible vaccines these pharmacies may provide can be found at **AlabamaBlue.com/VaccineNetworkDrugList**	**Tier 1 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 2 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 3 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 4 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 5 (Preferred Specialty) Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 6 (Non-Preferred Specialty) Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Covered Insulin Products:** $99 maximum cost share per 30-day supply; When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Extended Supply Prescription Prepaid Drug Benefits The extended supply pharmacy network for the plan is the **ValueONE ESN Network** • Locate a ValueONE ESN Pharmacy at **AlabamaBlue.com/ValueONEESNPharmacyLocator** Only maintenance prescription drugs can be purchased through this extended supply pharmacy service - up to a 90-day supply with one copay for each 30 day supply • View the Maintenance Drug List that applies to the plan at **AlabamaBlue.com/MaintenanceDrugList** • View the **Source+Rx 1.0** Drug list that applies to the plan at **AlabamaBlue.com/2024SourcePlusRx1DrugList**	**Tier 1 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 2 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 3 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 4 Drugs:** Covered at 80% of the allowed amount subject to calendar year deductible **Tier 5 (Preferred Specialty) Drugs:** Not covered **Tier 6 (Non-Preferred Specialty) Drugs:** Not covered **Covered Insulin Products:** $99 maximum cost share per 30-day supply; When a Covered Insulin Product qualifies as preventive care, the cost share cap applies whether or not deductible has been met. When a Covered Insulin Product does not qualify as preventive care, the cost share cap shall not apply until deductible has been met.	Not covered
Select Generic Specialty and Biosimilar Drugs Generic specialty and biosimilar drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some generic specialty and biosimilar drugs is the **Pharmacy Select Network**. • View the Select Generic Specialty and Biosimilar Drug List that applies to the plan at **AlabamaBlue.com/SelectGenericSpecialtyandBiosimilarDrugList.**	Covered at 100% of the allowed amount subject to calendar year deductible	Not covered
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse) **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 calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible
Chiropractic Services Limited to 15 visits per member per calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Durable Medical Equipment (DME)	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 80% of the allowed amount subject to calendar year deductible	Covered at 50% 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 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Autism-Related Rehabilitative and Habilitative Occupational and Speech Therapy Children ages 0-18 with an autism diagnosis are allowed unlimited visits for occupational and speech therapy	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
Home Health and Hospice	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Home Infusion	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Medical Nutrition Therapy Services For adults and children, 6 hours each calendar year	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 50% of the allowed amount subject to calendar year deductible
PEDIATRIC DENTAL BENEFITS		
Benefits are available up to the end of the month in which the member turns 19. See your benefit booklet for visit and treatment limits.		
Diagnostic and Preventive Services **Examples include:** Dental exams, routine cleanings, fluoride treatment, bitewing x-rays, full mouth x-rays and panoramic film, tooth sealants and topical fluoride varnish	Covered at 100% of the allowed amount subject to calendar year deductible	Not covered
Basic Services **Examples include:** Tooth color and silver amalgam fillings, simple tooth extractions, non-surgical root canal, emergency treatment for pain and repairs to crowns, inlays, onlays and dentures	Covered at 80% of the allowed amount subject to calendar year deductible	Not covered
Major Services **Examples include:** Oral surgery, general anesthesia, periodontic exams, removal of diseased gum tissue and bone, crowns, onlays, core buildup, dentures, implants and bridges	Covered at 50% of the allowed amount subject to calendar year deductible	Not covered
Medically Necessary Orthodontic Services	Covered at 50% of the allowed amount subject to calendar year deductible	Not covered
HEALTH MANAGEMENT AND ADDITIONAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call **1-800-821-7231**.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.	
Baby Yourself®	A maternity program; for more information, please call **1-800-222-4379**. You can also enroll online at **AlabamaBlue.com/BabyYourself**.	

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (**AlabamaBlue.com**) or call 1-800-810-BLUE (2583).*
- *In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area, 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.*
- *Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.*
- *Please refer to your benefit book or contact Blue Cross directly about coverage for your hospital charges and other related medical services. Approval for air medical transportation does not mean that hospitalization and other medical expenses will be covered. All coverage determinations for medical benefits are subject to the terms, conditions, limitations and exclusions of the health plan.*

This is not a contract, benefit booklet or Summary Plan Description.
***Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet)*.**
Check your benefit booklet for more detailed coverage information.
Please visit our website, AlabamaBlue.com.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama 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. ໂທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。