Blue Secure SILVER For Business

Plan Benefits Summary

For plan years beginning January 1, 2026 or later

BlueCross BlueShield of Alabama

Hospital Choice Network

The Blue Cross and Blue Shield of Alabama Hospital Choice Network is a local Alabama effort to evaluate cost, quality and patient experience in member hospitals. Hospitals are categorized into either Lower Member Cost Share or Higher Member Cost Share, based on their performance.

Only Alabama general acute care hospitals are eligible for participation in the Hospital Choice Network. Rehabilitation hospitals, psychiatric hospitals, specialty facilities, out-of-state hospitals, VA hospitals and long-term care hospitals are exempt from Hospital Choice Network scoring.

All hospitals are evaluated annually with changes made effective January 1. In addition, reviews are completed on a quarterly basis allowing hospitals to improve their status. To review the evaluation criteria for all hospitals and/or the level of Member Cost Share for a particular hospital, please use the "Find a Doctor" tool on our website at **AlabamaBlue.com.** The Member Cost Share level will be included in the information provided for each hospital that participates in the Hospital Choice Network. For more information on the evaluation criteria, click on the name of the hospital and then click on the "Cost", "Quality" or "Patient Experience" tabs. If you have any questions, please call the Customer Service number on the back of your ID card.

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 Secure Silver for Business
Effective for Plan Years on and after January 1, 2026
BlueCard® PPO

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.		
SUMMARY OF COST SHARING PROVISIONS (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 deductibles are separate and do not apply to each other	$4,200 Individual; $8,400 Family	$4,200 Individual; $8,400 Family
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	$9,200 Individual; $18,400 Family 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
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	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $700 per day hospital copay days 1-5 for each admission **Higher Member Cost Share:** Covered at 100% of the allowed amount after $1,000 per day hospital copay days 1-5 for each admission	Covered at 50% of the allowed amount after $1,500 per admission 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 subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount; no copay or deductible**	Covered at 50% of the allowed amount subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services covered at 50% of the allowed amount; no copay or 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)	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $650 hospital copay **Higher Member Cost Share:** Covered at 100% of the allowed amount after $950 hospital copay	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% of the allowed amount after $650 hospital copay	Covered at 100% of the allowed amount after $650 hospital copay **Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $650 hospital copay**
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 100% of the allowed amount after $650 hospital copay	Covered at 100% of the allowed amount after $650 hospital copay 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

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Physician	Covered at 100% of the allowed amount after $90 physician copay	Covered at 100% of the allowed amount after $90 physician copay **Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount after $90 physician copay**
Outpatient Diagnostic Lab, X-ray & Pathology	**Lower Member Cost Share:** Covered at 100% of the allowed amount after $650 hospital copay **Higher Member Cost Share:** Covered at 100% of the allowed amount after $950 hospital copay	Covered at 50% of the allowed amount subject to calendar year deductible; in Alabama, not covered
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or 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 100% of the allowed amount after $90 per day hospital copay	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.		
IN-NETWORK SERVICES *NOT* SUBJECT TO CALENDAR YEAR DEDUCTIBLE		
Office Visits, Consultations & Psychotherapy	Covered at 100% of the allowed amount after $45 primary care physician copay or $90 specialist physician copay	Covered at 50% of the allowed amount subject to calendar year deductible
Telephone and Online Video Physician Consultations Program- Medical and Behavioral Health To enroll in the telephone and online video consultations program, go to AlabamaBlue.com/Teleconsultation or call 1-800-997-6196. Telephone and online video consultations are available to diagnose, treat and prescribe medication (when necessary) for certain medical and behavioral health issues.	Covered at 100% of the allowed amount subject to a $45 copayment per consultation	Not covered
Second Surgical Opinion	Covered at 100% of the allowed amount after $90 physician copay	Covered at 50% of the allowed amount subject to calendar year deductible
Diagnostic X-ray	Covered at 100% of the allowed amount after $10 copay per procedure	Covered at 50% of the allowed amount subject to calendar year deductible
CAT Scan, MRI, PET/SPECT, ERCP, angiography/arteriography, cardiac cath/arteriography, UGI endoscopy, muga-gated cardiac scan & colonoscopy	Covered at 100% of the allowed amount after $650 copay per visit	Covered at 50% of the allowed amount subject to calendar year deductible
Diagnostic Lab, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount; no copay or deductible	Covered at 50% of the allowed amount subject to calendar year deductible
IN-NETWORK SERVICES SUBJECT TO CALENDAR YEAR DEDUCTIBLE		
Surgery & Anesthesia	Covered at 100% 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 100% 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
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
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

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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 Card The retail pharmacy network for the plan is the **ValueONE Retail Network**. • Locate a ValueONE Retail Network Pharmacy at **AlabamaBlue.com/ValueONERetailPharmacyLocator** 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/2026SourcePlusRx1DrugList** 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 may be combined for diabetic supplies Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some 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**	Covered at 100% of the allowed amount, subject to the following member cost share for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $30 copay per prescription **Tier 3 Drugs:** $75 copay per prescription **Tier 4 Drugs:** $100 copay per prescription **Tier 5 Drugs:** $250 copay per prescription **Tier 6 Drugs:** Covered at 40% of the allowed amount **Covered Insulin Products:** $99 maximum cost share per 30-day supply	Not covered
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/2026SourcePlusRx1DrugList**	Covered at 100% of the allowed amount, subject to the following member cost share for each prescription: **Tier 1 Drugs:** $15 copay per prescription **Tier 2 Drugs:** $30 copay per prescription **Tier 3 Drugs:** $75 copay per prescription **Tier 4 Drugs:** $100 copay per prescription **Tier 5 Drugs:** Not covered **Tier 6 Drugs:** Not covered **Covered Insulin Products:** $99 maximum cost share per 30-day supply	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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.** Generic specialty and biosimilar drugs are not available through the **Home Delivery Network**.	Covered at 100% of the allowed amount; no copay or deductible	Not covered
Mail Order Pharmacy Service • Up to 90-day supply with one copay • Mail Order drugs are available through **Home Delivery Network** (Enroll online at **AlabamaBlue.com/HomeDeliveryNetwork** **Note:** If you have less than a 90-day supply, you will pay the same copay as a 90-day supply when using this mail order service.	Covered at 100% of the allowed amount, subject to the following member cost share for each prescription: **Tier 1 Drugs:** $37.50 copay per prescription **Tier 2 Drugs:** $75 copay per prescription **Tier 3 Drugs:** $187.50 copay per prescription **Tier 4 Drugs:** $250 copay per prescription **Tier 5 Drugs:** Not covered **Tier 6 Drugs:** Not covered **Covered Insulin Products:** $99 maximum cost share per 30-day supply	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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
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 100% 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 100% of the allowed amount; no copay or 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 100% of the allowed amount after $45 physician copay	Covered at 50% of the allowed amount subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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; no copay or 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; no copay or 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**.	
Air Medical Transport	Air medical transportation to a network hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at **1-877-872-8624.**	

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. Air medical transportation services are provided through a contract with AirMed International, LLC, an independent company that does not provide Blue Cross and Blue Shield of Alabama products. Blue Cross is not responsible for any mistakes, errors or omissions that AirMed, its employees or staff members make. Air medical transportation services terminate if coverage by your health plan ends.*

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

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.

انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أي ظللمساعدات والخدمات اإلضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها **Arabic:** .مجانًا. اتصل بالرقم 1-
855-216-3144)الهاتف النصي: 711(أو االتصال بخدمة العمالء

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 નનિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોમેટમાં માહહતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ નવના મલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते िैं, तो आपके ललए ननिःशुल्क भाषा सियता सेवाएँ उपलब्ध िैं। आसान प्रारूप में सूचना उपलब्ध कराने के ललए उपयुक्त सियक साधन और सेवाएँ भी ननिःशुल्क उपलब्ध िैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्रािक 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.

BlueCross BlueShield of Alabama

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