The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsla.com or call 1-800-495-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-363-9150 to request a copy.

---

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Southern Regional Medical Providers: $3,000 individual or $6,000 family; <strong>network providers</strong> $3,000 individual or $6,000 family; for out-of-network providers $5,000 individual or $14,000 family</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive Care and Wellness are covered before you meet your deductible.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without <strong>cost-sharing</strong> and before you meet your <strong>deductible</strong>. See a list of covered <strong>preventive services</strong> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the Common Medical Events chart for other costs for services this <strong>plan</strong> covers.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Southern Regional Medical Providers: $4,800 individual or $13,500 family; <strong>network providers</strong> $4,800 individual or $13,500 family; for out-of-network providers Unlimited</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, Balance Billing Charges, and Health Care this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
</tbody>
</table>
### Will you pay less if you use a network provider?

Yes. See [www.bcbsla.com](http://www.bcbsla.com) or call 1-800-495-2583 for a list of network providers.

This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan’s network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider’s** charge and what your plan pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

### Do you need a referral to see a specialist?

No.

You can see the **specialist** you choose without a **referral**.

---

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Employer Preferred Option Provider (You will pay the least)</th>
<th>Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$75 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$75 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Cost</td>
<td>No Cost</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$125 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Employer Preferred Option Provider (You will pay the least)</td>
<td>Network Provider</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>$9 Copayment retail; $18 Copayment mail order</td>
<td>$15 Copayment retail; $45 Copayment mail order</td>
<td>Not Covered</td>
<td>Certain drugs may be subject to Quantity Level Limits, Step Therapy, and/or Prior Authorization requirements.</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>$25 Copayment retail; $50 Copayment mail order</td>
<td>$45 Copayment retail; $135 Copayment mail order</td>
<td>Not Covered</td>
<td>Certain drugs may be subject to Quantity Level Limits, Step Therapy, and/or Prior Authorization requirements.</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$45 Copayment retail; $90 Copayment mail order</td>
<td>$70 Copayment retail; $210 Copayment mail order</td>
<td>Not Covered</td>
<td>Certain drugs may be subject to Quantity Level Limits, Step Therapy, and/or Prior Authorization requirements.</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>25% Coinsurance up to $250 maximum</td>
<td>25% Coinsurance up to $250 maximum</td>
<td>Not Covered</td>
<td>Certain drugs may be subject to Quantity Level Limits, Step Therapy, and/or Prior Authorization requirements.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% Coinsurance after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$350 Copayment after deductible</td>
<td>$350 Copayment after deductible</td>
<td>$350 Copayment after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Ground &amp; Air: 0% Coinsurance after deductible</td>
<td>Ground &amp; Air: 0% Coinsurance after deductible</td>
<td>Ground &amp; Air: 0% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 Copayment / $75 Copayment</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-363-9150
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bcbsla.com](http://www.bcbsla.com) or [www.healthcare.gov](http://www.healthcare.gov) or call 1-800-363-9150 to request a copy.
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Employer Preferred Option Provider (You will pay the least)</th>
<th>Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 Copayment after deductible per day up to 7 days</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Must obtain authorization.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% Coinsurance after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Mental/Behavioral outpatient services</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral inpatient services</td>
<td>$250 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Must obtain authorization.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$250 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Must obtain authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Dependent maternity is covered under this Benefit Plan.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$500 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Authorization required if the mother’s length of stay exceeds 48 hours following a vaginal delivery or 96 hours following a caesarean section.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% Coinsurance after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Must obtain authorization. 60 visit limits per Benefit Period.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Physical &amp; Occupational Therapy have a combined 60 visit limit per Benefit Period. 60 visit limits per Benefit Period for Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$50 Copayment after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
<td>Physical &amp; Occupational Therapy have a combined 60 visit limit per Benefit Period. 60 visit limits per Benefit Period for</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employer Preferred Option Provider (You will pay the least)</td>
<td>Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$250 Copayment after deductible per day up to 7 days</td>
<td>20% Coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% Coinsurance after deductible</td>
<td>20% Coinsurance after deductible</td>
<td>50% Coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$50 Copayment after deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

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

- Cosmetic Surgery
- Dental Care
- Long-Term Care
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing
- Routine Eye Care
**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.Healthcare.gov](http://www.Healthcare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

**Does this plan provide Minimum Essential Coverage?** Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-495-2583
Navajo (Dine): Dinek'ehgo shika a'tohwol ninisingo, kwijijgo holne'1-800-495-2583

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

Questions: Call 1-800-363-9150
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About these Coverage Examples:

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

---

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $3,000
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$350</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
<td>$80</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60
- The total Peg would pay is: $4,860

---

**Managing Joe’s type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $3,000
- Specialist coinsurance: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
<td>$2,060</td>
</tr>
<tr>
<td>Copayments</td>
<td>$630</td>
<td>$350</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$80</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60
- The total Joe would pay is: $3,770

---

**Mia’s Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $3,000
- Specialist copayment: 20%
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,060</td>
<td>$2,060</td>
</tr>
<tr>
<td>Copayments</td>
<td>$350</td>
<td>$350</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60
- The total Mia would pay is: $2,410

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
Nondiscrimination Notice
Discrimination is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc., does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Blue Cross and Blue Shield of Louisiana and its subsidiaries:

• Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (audio, accessible electronic formats)
• Provide free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@bcbsla.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Blue Cross, one of its subsidiaries or your employer-insured health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps;

1. If you are fully insured through Blue Cross, file a grievance with Blue Cross by mail, fax, or email.

   Section 1557 Coordinator
   P. O. Box 98012
   Baton Rouge, LA 70898-9012
   225-298-7238 or 1-800-711-5519 (TTY 711)
   Fax: 225-298-7240
   Email: Section1557Coordinator@bcbsla.com

2. If your employer owns your health plan and Blue Cross administers the plan, contact your employer or your company’s Human Resources Department. To determine if your plan is fully insured by Blue Cross or owned by your employer, go to www.bcbsla.com/checkmyplan.

Whether Blue Cross or your employer owns your plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights 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, 800-537-7697 (TDD)

Or

NOTICE

Free language services are available. If needed, please call the Customer Service number on the back of your ID card. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios lingüísticos gratutitos. De necesitarlos, por favor, llame al número del Servicio de Atención al Cliente que aparece en el reverso de su tarjeta de identificación. Clientes con dificultades auditivas, llamen al 1-800-711-5519 (TTY 711).

Des services linguistiques gratuits sont disponibles. Si nécessaire, veuillez appeler le numéro du Service clientèle figurant au verso de votre carte d'identification. Si vous souffrez d'une déficience auditive, veuillez appeler le 1-800-711-5519 (TTY 711).


我们为您提供免费的语言服务。如有需要，请致电您 ID 卡背面的客户服务号码。听障客户请拨 1-800-711-5519（TTY 711）。

إذا كنت تتلقى من إعالة في السمع، فاصل الاتصال بالرقم 1-800-711-5519 (TTY 711).


우료 없어 서비스를 이용하실 수 있습니다. 필요한 경우 귀하의 ID 카드 뒷면에 기재되어 있는 고객 서비스 번호로 연락하시기 바랍니다. 청각 장애가 있는 분은 1-800-711-5519 (TTY 711)로 연락하십시오.

Oferecemos serviços linguísticos gratuitos. Caso necessário, ligue para o número de Atendimento ao Cliente indicado no verso de seu cartão de identificação. Caso tenha uma deficiência auditiva, ligue para 1-800-711-5519 (TTY 711).

ขออภัยถ้าบริการไม่พึงพอใจท่าน. ท่านสามารถสอบถามข้อมูลเพิ่มเติม, ระดับการสื่อสารแบบอิเล็กทรอนิกส์อัตโนมัติ (TTS), หรือพนักงานที่มีความสามารถในภาษาไทย.

菲律宾语服务可用。如需帮助，请拨打客户服务中心电话 (TTY 111)。

無料の言語サービスをご利用頂けます。あなたのIDカードの裏面に記載されているサポートセンターの電話番号までご連絡ください。聴覚障害がある場合は、1-800-711-5519 (TTY 711)までご連絡ください。


