Standard Self-Funded

Member Appeals and Grievance Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET. KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL ADVERSE DETERMINATIONS MADE ABOUT YOUR HEALTHCARE.

An Independent Licensee of the Blue Cross Blue Shield Association

DISPUTES ELIGIBLE FOR THE HEALTHCARE APPEALS PROCESS

You can file an appeal when AZ Blue notifies you of an "Adverse Determination." This happens when we decide that a requested service or a claim for service or a denial, reduction, or termination of service, in whole or in part, is:

Not medically necessary or appropriate, including the healthcare setting, level of care, or effectiveness of a treatment or service.	Experimental or investigational.	Not a covered service.

An Adverse Determination also includes: (i) a cancellation of the policy back to the effective date due to a reason other than failure to pay premiums, known as a "rescission of coverage" and (ii) when we decide that an out-of-network claim is not subject to protections from balance billing under the federal No Surprises Act, but you think it should be

Some disputes can't be appealed. For example, you disagree with:

- The amount we paid for a service or treatment
- How we are coordinating benefits when you have coverage with more than one insurer
- The amount we applied for your deductible or out-of-pocket maximum
- The amount we calculated for your cost share obligation like copayments and coinsurance

If you disagree with these kinds of decisions, you can dispute them through other processes. Contact us to ask about filing a member grievance. Also see page 14 of this packet.

WHO CAN FILE A HEALTHCARE APPEAL OR GRIEVANCE?

You can file an appeal for yourself. The following authorized representatives can also file an appeal on your behalf and do not need any special authorization form:

- Your treating provider acting on your behalf
- A parent on behalf of a minor

If you are a member filing an appeal, you can work with your treating provider to help you with supporting information, such as medical records. In Arizona, most healthcare appeals are filed by treating providers acting on behalf of their patients.

The individuals listed below also may appeal a decision for you, if you send AZ Blue the required proof of authority:

Third Party Representative	Proof of Authority
Member's Legal Guardian	Official copy of the court order appointing the guardian
Your Agent	Durable Power of Attorney that complies with A.R.S. § 14-5501 (or equivalent statute from other state) authorizing the agent to appeal or grieve a healthcare decision; or A Health Care Power of Attorney that complies with A.R.S. § 36-3221 (or equivalent) and authorizes the agent to make healthcare treatment decisions for you
Your Surrogate	Someone who qualifies as a surrogate as defined by A.R.S. §36-3231 (or equivalent statute from another state) and Includes a written confirmation from a treating provider that the member is unable to make or communicate healthcare treatment decisions
Executor or Personal Representative	Official copies of the death certificate and court order appointing the executor or personal representative
Court Appointed Representative	Adult authorized by any other type of court order to make healthcare decisions for a member Official copy of the court order

If AZ Blue receives an appeal or grievance request from a third party (other than your treating physician) who claims to be your authorized representative, including the examples in the table above, AZ Blue may require you to confirm to us in writing the scope of the third party's authorization. We may not recognize the third party's authority until we receive your confirmation.

TOOLS FOR FILING A HEALTHCARE APPEAL

In this packet you will find forms you can use for your appeal. You are not required to use them and we cannot reject your appeal if you do not use them. To file an appeal, you can call us or send us a request in writing. If you need help in filing an appeal, or you have questions about the appeals process, call us at the phone number shown on the back of your ID card or listed on the CONTACT US page in this packet.

DESCRIPTION OF THE APPEALS PROCESS

There are two types of appeal time frames:

- a standard appeal
- an expedited appeal for urgent matters

The appeals processes operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Appeals are categorized as either Medical Necessity or Coverage. The designation will affect how the case is handled by AZ Blue . It also will affect the rights you have once the healthcare appeals process has been completed.

STANDARD VS EXPEDITED TIME FRAMES: IS IT URGENT

If your appeal is urgent and is for a service that hasn't yet been provided, your treating provider must certify and provide supporting documentation to us that the time frame for a standard appeal review (15 days) would cause a significant negative change in your condition. At the end of this packet, there is a form that a treating provider can use to make the required certification. Instead of this form, your provider could also send a written request or create a form with similar information. Your treating provider must send the certification and any supporting documentation to us using the information on the CONTACT US page in this packet.

Expedited appeals can only be used for services that haven't yet been provided. Here are some examples, but this isn't a complete list:

- You are in a course of treatment and we have said we won't approve continuation of the treatment.
- We denied prior authorization for a service that you need to avoid permanent harm, severe pain, or significant deterioration in your condition.

GENERAL APPEALS PROCESS INFORMATION

- You have **two years** from the date of an Adverse Determination to begin the healthcare appeals process.
- You must send requests for **all** healthcare appeal levels directly to AZ Blue using the information on the CONTACT US page in this packet.
- AZ Blue handles the First and Second Levels of Internal Appeal and the Expedited First and Second Levels of Internal Appeal.
- At the end of the internal review process, AZ Blue sends cases involving questions of medical judgment to an external independent medical reviewer.
  1. Cases based on "medical judgment" include:
     - Medical necessity
     - Medical appropriateness
     - Level of care
     - Benefit effectiveness
     - Investigational or experimental treatment
  2. Members of grandfathered plans may also appeal contract coverage cases to an external independent reviewer.
- Your appeal must go through a First Level Internal Appeal and a Second Level Internal Appeal. These internal levels of review must be waived or deemed exhausted, before you can seek an External Review. You may simultaneously initiate an Expedited External Review at any internal level of review for urgently needed services that you have not yet received.
- At any time, AZ Blue may waive the internal levels of review and move an appeal to the External Review level.
- Before AZ Blue makes a Final Internal Adverse Determination that relies on new or additional information received by AZ Blue, we will provide you with a copy of the new or additional information, free of charge, to allow you an opportunity to respond.
- To qualify for the healthcare appeals process, there is no minimum dollar amount for the value of a claim or service.
- There is no fee to you or your provider for any level of appeal.
- It is important to pay attention to deadlines at each level of review.
- You have **three standard appeal levels.** The three standard appeal levels are:
  1. First Level Internal Appeal
  2. Second Level Internal Appeal
  3. External Review
- You also have **three expedited appeal levels** for services that you have not yet received, when your provider certifies that your condition qualifies as urgent because waiting 15 days for the standard appeal time period could:
  1. Jeopardize your life, health, or ability to regain maximum function
  2. Cause a significant negative change in your medical condition
  3. Subject you to severe pain that cannot be managed without the requested service
- The **three expedited appeal levels** are:
  1. Expedited First Level Internal Appeal
  2. Expedited Second Level Internal Appeal
  3. Expedited External Review
- If the External Review involves a medical judgment issue, AZ Blue sends the review to an external independent reviewer (IRO)I that is completely independent of AZ Blue to make the determination. The IRO reviewer will be a provider that typically manages the condition that is the subject of the appeal.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

• First Level Internal Appeal

You can request a First Level Internal Appeal of an Adverse Determination **if all of the following apply:**

- You request an appeal within **two years** after the date we make the Adverse Determination.
- You Were an eligible member on the date of service.
- We denied your request for a covered service or claim.
- You do not qualify to have your appeal expedited.
- You send your request to us using the information in the CONTACT US page in this packet.

At any time, AZ Blue may decide to waive the internal review and send your appeal to an external Independent Review Organization (IRO) for External Review.

If we overturn our original denial, we will authorize the service or pay the claim and the appeal is over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the appeal process.

You have **60 days** to request a Second Level Internal Appeal.

• Second Level Internal Appeal

You or your treating provider must send a request for a Second Level Internal Appeal within **60 days** of receiving the First Level Internal Appeal determination.

To help us decide your second level appeal, you or your provider should send us any additional information that you have not already sent to show why we should authorize the requested service or pay the claim. Send your appeal request and information to us using the information on the CONTACT US page in this packet.

AZ Blue may decide at any time to waive the Second Level Internal Appeal and send your appeal to an external Independent Review Organization for External Review.

If we overturn our denial, we will authorize the service or pay the claim and the appeal will be over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision will also include instructions for the next steps in the appeal process.

You have **four months from the date of our second level decision** to appeal to the External Review level.

Determination Time Frames for Both Internal Appeal Levels:

AZ Blue has:

- **15 days** to decide for a service not yet provided
- **30 days** to decide for a service already provided

EXTERNAL REVIEW

You may appeal to the External Review level only after you have completed the internal levels of appeal. You must file your request for External Review within four months after you receive the Second Level appeal decision. Send us your written appeal request and any additional supporting information using the information on the CONTACT US page in this packet.

This level of review also applies if we elect to waive the internal level(s) of review.

- Your External Review will be sent for an external independent medical review, if it involves a question of medical judgment or a rescission of coverage.
- Within **five business days** of receiving your request, AZ Blue will:
  - Cases based on "medical judgment" include:
    - Medical necessity
    - Medical appropriateness
    - Health care setting
    - Level of care
    - Benefit effectiveness
    - Investigational or experimental treatment
- Members of grandfathered plans may also appeal contract coverage denials to external review
- External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.
- After getting your request, AZ Blue has 5 business days to decide if your request is eligible for external review.
  - BCBSAZ notifies you within one additional business day if your case is not eligible for external review or if your submission is incomplete.
  - If your submission is incomplete, you have up to the 4 month period to submit any missing information.
  - If the time has expired, you have 48 hours after you received AZ Blue's notice of incomplete submission to send the missing information.

Non-Grandfathered Plans:

1. The IRO notifies you when it has accepted your case.
2. You have up to 10 business days to provide the IRO with more information that you want the IRO to consider.
3. If you provide the IRO with new information, the IRO has 1 business day to send it to AZ Blue. Based on the new information, AZ Blue may decide to change its internal decision, and would notify you and the IRO of this change.
4. The IRO must issue a decision within 45 days after receiving the request for external review.
   a. If the IRO modifies the decision in your favor, AZ Blue must comply with the IRO's decision.
   b. If the IRO upholds AZ Blue's decision, you may have other legal recourse to challenge AZ Blue's decision in court.

Grandfathered Plans

1. The IRO must make a decision within 21 days of receiving the appeal from AZ Blue.
2. AZ Blue mails the decision to you and your treating provider, within 5 business days of receiving the decision from the IRO.
   a. If the IRO modifies the decision in your favor, AZ Blue must comply with the IRO's decision.
   b. If the IRO upholds AZ Blue's decision, you may have other legal recourse to challenge BCBSAZ's decision in court.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

• Expedited First Level Internal Appeal

You may obtain an Expedited First Level Internal Appeal of an Adverse Determination for a service you haven't yet received if your treating provider certifies in writing and provides supporting documentation that the time for a standard appeal is likely to cause a significant negative change in your medical condition.

At the end of this packet is a form that your treating provider may use for the certification, but that form is not required. Your provider could also provide a written request or create a form with similar information. Your treating provider must send the certification and any supporting documentation to us using the information on the CONTACT US page in this packet.

AZ Blue has **72 hours** after we receive the request to decide whether we should change our determination and authorize your requested service. Within this time frame, we will call and tell you and your treating provider about our decision. We will also send you a written decision letter.

If we overturn our determination, we will authorize the service and the appeal is over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Internal Level Appeals and send your appeal to an Independent Review Organization for Expedited External Review.

• Expedited Second Level Internal Appeal

If we uphold the denial in your Expedited First Level Internal Appeal, you may request an Expedited Second Level Internal Appeal.

After you receive our Expedited First Level Internal Appeal decision, your treating provider must immediately send us a written appeal request using the information on the CONTACT US page in this packet. To help your appeal, your provider should also send us any additional information that the provider has not already sent to show why you need the requested service.

Within **72 hours** after we receive the request, we will decide whether we should change our denial decision and authorize your requested service. Within this time frame, we will call and tell you and your treating provider about our decision. We will also send you a written decision letter.

If we overturn our determination, we will authorize the service and the appeal is over.

If we uphold the denial, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the appeal process.

We may decide at any time to waive the Expedited Second Level Internal Appeal level and send your appeal to an external Independent Review Organization (IRO) for Expedited External Review.

EXPEDITED EXTERNAL REVIEW

Unless we waive the Expedited First Level Internal Appeal or Expedited Second Level Appeal levels of review and send your appeal to an external IRO for Expedited External Review, you may request an Expedited External Review after you have completed an Expedited First Level Internal Appeal and an Expedited Second Level Internal Appeal or simultaneously at any internal level of review.

You have four months after you receive our Final Internal Adverse Determination to send to us your written request for Expedited External Review. If the treatment or service is considered experimental or investigational, you can make an oral request if your treating provider certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated. Send us your request and any additional supporting information using the information on the CONTACT US page in this packet.

This level of review also applies if we elect to waive the internal level(s) of review.

- Your Expedited External Review will be sent to an external independent medical review, if it involves a question of medical judgment or a rescission of coverage.
- Cases based on "medical judgment" include:
  - Medical necessity
  - Medical appropriateness
  - Health care setting
  - Level of care
  - Benefit effectiveness
  - Investigational or experimental treatment
- Members of grandfathered plans may also appeal contract coverage denials to external review.
- External review is not available for denials based on lack of member eligibility or for payment disputes that do not involve questions of medical judgment.
- You have up to 4 months from the date of the final internal review decision to submit a written request for external review.
- After getting your request, AZ Blue has 1 business day to decide if your request is eligible for external review.
  - BCBSAZ notifies you within one additional business day if your case is not eligible for external review or if your submission is incomplete.
  - If your submission is incomplete, you have up to the 4 month period to submit any missing information.
  - If the time has expired, you have 48 hours after you received AZ Blue's notice of incomplete submission to send the missing information.

Non-Grandfathered Plans:

1. The IRO notifies you when it has accepted your case.
2. You have up to 10 business days to provide the IRO with more information that you want the IRO to consider.
3. If you provide the IRO with new information, the IRO has 1 business day to send it to BCBSAZ. Based on the new information, AZ Blue may decide to change its internal decision, and would notify you and the IRO of this change.
4. The IRO must issue a decision as quickly as possible in light of the medical circumstances, but no later than 72 hours after receiving the request for external review.
   a. If the IRO's decision is not issued in writing, the IRO has another 48 hours to provide written confirmation of the decision.
   b. If the IRO modifies the decision in your favor, AZ Blue must comply with the IRO's decision.
   c. If the IRO upholds AZ Blue's decision, you may have other legal recourse to challenge AZ Blue's decision in court.

Grandfathered Plans

1. The IRO must make a decision within 21 days of receiving the appeal from AZ Blue.
2. AZ Blue mails the decision to you and your treating provider, within 5 business days of receiving the decision from the IRO.
   a. If the IRO modifies the decision in your favor, AZ Blue must comply with the IRO's decision.
   b. If the IRO upholds AZ Blue's decision, you may have other legal recourse to challenge BCBSAZ's decision in court.

THE ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS (AZ DIFI)

Because your plan is not a fully insured plan regulated under Arizona state law, the Arizona Department of Insurance and Financial Institutions does not have regulatory authority over your complaint about the plan.

DOCUMENTATION FOR AN APPEAL

- If you file an appeal, you must include any material justification or documentation.
- If you gather new information during the course of your appeal you should give it to us as soon as you get it.
- You must give us the address and phone number or email where you can be contacted.
- If you submit anything after the **five business days,** it does not have to be considered in your appeal.

RECEIPT OF DOCUMENTS

Any written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the **fifth business day** after mailing. "Properly addressed" means your last known mailing address. Any document may alternatively be sent electronically where a member has elected electronic delivery.

OBTAINING MEDICAL RECORDS

Arizona law (A.R.S. § 12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and specify who you want to receive the records. The healthcare provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated healthcare decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your healthcare decision-maker or a person designated in writing by your healthcare decision-maker unless you limit access to your medical records only to yourself or your healthcare decision-maker.

Confidentiality: Medical records disclosed under A.R.S. § 12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

If you reside outside the state of Arizona, the laws that govern medical records and providers in your state may vary.

MEMBER GRIEVANCE PROCESS FOR DISPUTES ABOUT MEMBER COST SHARE AND PLAN ALLOWED AMOUNT

• First Level Member Grievance

You can request a First Level Member Grievance if you disagree with the member cost share or the plan allowed amount, if **all** of the following apply:

- You request a grievance within one year after the date we make the decision you want to grieve.
- You were an eligible member on the date of service.
- You send your request to us using the information on the CONTACT US page in this packet.

• Determination and Time Frames

- AZ Blue has **30 days** to make a decision.
- AZ Blue will send you and your treating provider a written decision letter.

If we overturn our original determination, we will reprocess the claim and the grievance is over.

If we uphold the current processing of the claim, our decision letter will explain the reasons why and the information on which we based our decision. Our decision letter will also include instructions for the next steps in the grievance process. You will have 60 days to request a Second Level Member Grievance.

• Second Level Member Grievance

You have 60 days after receiving the First Level Member Grievance determination to send a written request for a Second Level Member Grievance.

Determination and Time Frames

- AZ Blue has **30 days** to make a decision.
- AZ Blue will send you and your treating provider a written decision letter **If we overturn our determination,** we will reprocess the claim and the grievance is over.

If we uphold the current processing of the claim, our decision letter will explain the reasons why and the information on which we based our decision. This will be the end of the grievance process. No further review will be available.

You may have other legal recourse by challenging AZ Blue's decision in court.

CONTACT US

Contact us if you have questions with how we processed your claim.

Call AZ Blue Customer Service Monday through Friday, 8 a.m. to 4:30 p.m. MST (except holidays) using the phone number on the back of your member ID card or at **602-864-4400** or **1-800-232-2345.**

For an appeal or member grievance call, fax, or write to:	Chiropractor Services
AZ Blue Attn: Medical Appeals & Grievances Coordinator P.O. Box 13466–Mail stop A116 Phoenix, AZ 85002-3466 Phone: 602-864-4400 or 1-800-232-2345 Fax: 602-544-5601 Email: appeals@azblue.com	American Specialty Health Networks, Inc. Attn: Appeals Coordinator P.O. Box 509140 San Diego, CA 92150 Phone: 1-800-972-4226 Fax: 1-877-404-2746

Appeal Resources

AZ Blue customer service representatives can answer questions about the appeal process and help you with filing an appeal. The AZ Blue customer service number is **602-864-4400** or **1-800-232-2345 (toll free).**

The appeal and grievance rights in this packet are in additional to your rights to challenge the decision in court. For many group plans (other than government plans and church plans), court action may include legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). If you are enrolled in an ERISA qualified group plan, you and your plan may have other voluntary alternative dispute resolution options in addition to the appeals and grievance processes described in your benefit plan booklet, such as mediation.

You can contact the U.S. Department of Labor – Employee Benefits Security Administration at **1-866-444-EBSA (3272).** You may also be able to obtain information from your group benefits administrator.

If you are hearing impaired (TTY), please call **602-864-4823** or **1-800-232-2345, ext. 4823.**

BlueCross BlueShield Arizona

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Appeal/Grievance Request Form

You may use this form to tell AZ Blue you want to appeal or grieve a decision.

Member Name ______________________________

Member ID # ______________________ Group # ______________

Name of representative pursuing appeal, if different than above ______________________

Phone # ______________________________

Mailing Address ______________________________

City ______________ State ______ ZIP Code ______________

Type of Appeal/Grievance ☐ Denied Claim ☐ Denied Service Not Yet Receive ☐ Cost Share Dispute

Claim # (if applicable) ______________ Date of Service ____ / ____ / ____

If you are appealing AZ Blue's decision to deny a service you have not yet received, could a 15 to 30 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function, cause a significant negative change in your medical condition, or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider can send us the attached certification and documentation supporting the need for an expedited appeal.

What action or decision are you disputing? ______________________________

Explain why you believe the decision or action was wrong and what you would like AZ Blue to do differently:

____

____

____

(Attach additional sheets of paper, if needed)

If you have questions about the appeal or grievances process or need help to prepare your request, please call AZ Blue at **602-864-4400** or **1-800-232-2345.**

Make sure that everything that shows why you believe AZ Blue should process your claim differently or authorize a service, including: ☐ Medical Records ☐ Supporting Documentation (letter from your doctor, brochures, notes, receipts, etc.) You may attach the certification from your treating provider if you are seeing an expedited review. Send to:

Blue Cross Blue Shield of Arizona
Attn: Medical Appeals and Grievances Coordinator
P.O. Box 13466, Mail stop A116
Phoenix, AZ 85002-3466
Phone: 602-544-4938 or 1-866-595-5998
Fax: 602-544-5601

Signature of member or authorized representative ______________________ Date___/____/______

Provider Certification Form for Expedited Appeal

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Is the appeal for a service that the patient has not yet received? ☐ ***Yes*** ☐ ***No***
If "Yes," continue with this form.
If "No," the patient must pursue the standard appeal process and cannot use the expedited appeals process.

Provider Information		
Treating Physician/Provider		
Phone #	Fax #	
Address		
City	State	ZIP Code

Patient Information		
Member Name		
Member ID #	Group #	
Phone #	Fax #	
Address		
City	State	ZIP Code

What service denial is the patient appealing? ______________________________

____

____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient: ______________________________

____

____

Fax this form with any supporting documentation and medical records to:
AZ Blue at **602-544-5601.**

I certify, as the patient's treating provider, that delaying the patient's requested service for the time periods applicable to the standard appeal process is likely to seriously jeopardize the patient's life, health, or ability to regain maximum function, cause a significant negative change in their medical condition, or subject the patient to severe pain that cannot be adequately managed without the requested service.

Provider's Signature: ______________________________ Date _____/_____/_______

Printed Name: ______________________________

If you have questions about the appeals process or need help to prepare your appeal, please call AZ Blue at **602-864-4400** or **1-800-232-2345.**

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

English: 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 1-800-446-8331 (TTY: 711).

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-446-8331 (TTY: 711).

Navajo: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-800-446-8331 (TTY: 711).

Chinese Simplified: 如果您说[中文]，我们将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，以无障碍格式提供信息。致电 1-800-446-8331（文本电话：711）。

Chinese Traditional: 如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-446-8331（TTY：711）。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-446-8331 (TTY: 711).

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-446-8331 (TTY: 711).

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-446-8331 (Người khuyết tật: 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-446-8331 (TTY: 711).

Korean: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-446-8331 (TTY: 711).

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-446-8331 (TTY: 711).

Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) 1-800-446-8331.

Hindi: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-446-8331 (TTY: 711) ।

Farsi (Persian)

توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره (تله‌تایپ: TTY: 711) 1-800-446-8331

Thai: หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-446-8331 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

Japanese: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-446-8331（TTY：711）。

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