



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by visiting [www.chouest.com](http://www.chouest.com) or by calling (985) 601-4301.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network Providers: <b>\$652</b> Person/ <b>\$1,956</b> Family; Non-Network Providers: <b>\$652</b> Person/ <b>\$1,956</b> Family; Per Calendar Year	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the Common Medical Event chart for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. Prescription Drug Deductible: <b>\$50</b> Person/ <b>\$100</b> Family; Per Calendar Year	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Network Providers: <b>\$1,950</b> Person/ <b>\$3,900</b> Family; Non-Network Providers: <b>\$3,250</b> Person/ <b>\$6,500</b> Family; Per Calendar Year	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Member Cost Share, Balance Billed Charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Event chart describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a full listing of participating providers, see <a href="http://www.bcbsla.com">www.bcbsla.com</a> or call 1-800-495-2583.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the Common Medical Event chart for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

**Questions:** Call (985) 601-4301.

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 1-800-495-2583 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in Excluded Services & Other Covered Services. See your policy or plan document for additional information about <b><u>excluded services</u></b> .
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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Preferred **providers** by waiving or charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$32 copayment per visit	30% coinsurance after deductible & \$32 copayment	Labs, x-rays, injections, etc. are applied to the deductible.
	Specialist visit	\$32 copayment per visit	30% coinsurance after deductible & \$32 copayment	Labs, x-rays, injections, etc. are applied to the deductible.
	Other practitioner office visit	20% coinsurance after deductible	30% coinsurance after deductible & \$32 copayment	Labs, x-rays, injections, etc. are applied to the deductible.
	Preventive care/screening	\$32 copayment per visit	\$32 copayment per visit; then 30% coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	None

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# GALLIANO MARINE SERVICE, L.L.C.

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible Bone Mass Measurement: 50% coinsurance after deductible	30% coinsurance after deductible Bone Mass Measurement: 50% coinsurance after deductible	Must obtain authorization.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.chouest.com">www.chouest.com</a> .	Generic Drugs	\$15 copayment retail; \$5 copayment mail order	\$15 copayment retail; \$5 copayment mail order	Deductible is not applicable.
	Brand Drugs	35% retail; 30% mail order (maximum \$75 copayment retail; maximum \$225 copayment mail order)	35% retail; 30% mail order (maximum \$75 copayment retail; maximum \$225 copayment mail order)	Prescription drug deductible must be satisfied before copayments are applicable.
	Specialty Drugs	10% (\$75 minimum/\$150 maximum) 25% (\$500 maximum)	Not Covered	Prescription drug deductible must be satisfied before copayments are applicable.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	None
<b>If you need immediate medical attention</b>	Emergency room services	20% coinsurance after deductible	30% coinsurance after deductible	None
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance after deductible	Authorization required for non-emergency care.
	Urgent care	\$32 copayment per visit	30% coinsurance after deductible & \$32 copayment	None

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# GALLIANO MARINE SERVICE, L.L.C.

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
	Physician/surgeon fee	20% coinsurance after deductible	30% coinsurance after deductible	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization for services over three (3) hours.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
	Substance use disorder outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization for services over three (3) hours.
	Substance use disorder inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization. Failure to do so will result in no benefit if not medically necessary.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	30% coinsurance after deductible	Maternity benefits are available for Subscriber or Spouse only.
	Delivery and all inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Inpatient admissions of more than 48 hours following routine vaginal deliveries require authorization. Inpatient admissions of more than 96 hours following cesarean section deliveries require authorization.

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# GALLIANO MARINE SERVICE, L.L.C.

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization.
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization.
	Habilitation services	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization.
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization.
	Durable medical equipment (DME)	20% coinsurance after deductible C-PAP machines & related equipment: 50% coinsurance after deductible	30% coinsurance after deductible C-PAP machines & related equipment: 50% coinsurance after deductible	Must obtain authorization for DME greater than \$300. All services that are payable at 50/50% Coinsurance do not apply to the Out-of-Pocket Amount and are never payable at 100%.
	Hospice service	20% coinsurance after deductible	30% coinsurance after deductible	Must obtain authorization.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing (Outpatient)

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 985-601-4301. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross and BlueShield of Louisiana at 1-800-495-2583 or [www.bcbsla.com](http://www.bcbsla.com) OR the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Having a baby**  
(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,475
- Patient pays \$2,065

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Inpatient Medications	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$573
Co-pays	\$0
Coinsurance	\$1,342
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,065</b>

**Managing type 2 diabetes**  
(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,699
- Patient pays \$1,701

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits	\$250
Procedures	\$450
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$600
Co-pays	\$850
Coinsurance	\$172
Limits or exclusions	\$79
<b>Total</b>	<b>\$1,701</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance.

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Blue Cross and Blue Shield of Louisiana  
HMO Louisiana  
Southern National Life

## **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](http://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

Electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# 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 gratuitos. 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).

Có dịch vụ thông dịch miễn phí. Nếu cần, xin vui lòng gọi cho Phục Vụ Khách Hàng theo số ở mặt sau thẻ ID của quý vị. Khách hàng nào bị suy giảm thính lực hãy gọi số 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)。

الخدمات اللغوية متاحة مجاناً. يرجى، إذا اقتضى الأمر، الاتصال برقم خدمة العملاء المدون على ظهر بطاقة التعريف الخاصة بك. إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بالرقم 1-800-711-5519 (TTY 711).

Magagamit ang mga libreng serbisyo sa wika. Kung kinakailangan, pakitawagan ang numero ng Customer Service sa likod ng iyong ID kard. Para sa mga may kapansanan sa pandinig tumawag sa 1-800-711-5519 (TTY 711).

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

Oferecemos serviços linguísticos grátis. 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).

ພວກເຮົາມີບໍລິການແປພາສາໄທ້ທ່ານຟຣີ. ຖ້າທ່ານຕ້ອງການບໍລິການນັ້ນ, ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຕາມເບີໂທທີ່ຢູ່ທາງຫຼັງຂອງບັດປະຈຳຕົວຂອງທ່ານ. ຖ້າທ່ານຫຼຸບໍ່ໄດ້, ຂໍໃຫ້ໂທເບີ 1-800-711-5519 (TTY 711).

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 (TTY711)までご連絡ください。

زبان سے متعلق مفت خدمات دستیاب ہیں۔ اگر ضرورت ہو تو، براہ کرم اپنے آئی ڈی کارڈ کی پشت پر موجود کسٹمر سروس نمبر پر کال کریں۔ سمعی نقص والے کسٹمرز 1-800-711-5519 (TTY 711) پر کال کریں۔

Kostenlose Sprachdienste stehen zur Verfügung. Falls Sie diese benötigen, rufen Sie bitte die Kundendienstnummer auf der Rückseite Ihrer ID-Karte an. Hörbehinderte Kunden rufen bitte unter der Nummer 1-800-711-5519 (TTY 711) an.

خدمات رایگان زبان در دسترس است. در صورت نیاز، لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی تان درج شده است تماس بگیرید. مشتریانی که مشکل شنوایی دارند با شماره 1-800-711-5519 (TTY 711) تماس بگیرند.

Предлагаются бесплатные переводческие услуги. При необходимости, пожалуйста, позвоните по номеру Отдела обслуживания клиентов, указанному на оборотной стороне Вашей идентификационной карты. Клиенты с нарушениями слуха могут позвонить по номеру 1-800-711-5519 (Телефон с текстовым выходом: 711).

มีบริการด้านภาษาให้ใช้ได้ฟรี หากต้องการ โปรดโทรศัพท์ติดต่อฝ่ายการบริการลูกค้าตามหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของท่าน สำหรับลูกค้าที่มีปัญหาทางการได้ยิน โปรดโทรศัพท์ไปที่หมายเลข 1-800-711-5519 (TTY 711)