



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, <https://eoc.anthem.com/eocdps/>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (844) 855-1950 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0.                                                                                                                                                                                                                             | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | No.                                                                                                                                                                                                                              | You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$3,000/individual or \$6,000/family for In- <a href="#">Network Providers</a> . This <a href="#">plan</a> has a separate Out of Pocket Maximum of \$3,600/individual or \$7,200/family for <a href="#">Prescription Drugs</a> . | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                        | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, Anthem BC HMO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (844) 855-1950 for a list of <a href="#">network providers</a> .                                                                        | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?                                                                                                                                                                                              | Yes.                                                                                | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> . |                                                                                                                                                       |                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  All <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> applies. |                                                                                     |                                                                                                                                                                                                                      |                                                                                                                                                       |                                                                                                                                                                                                                                                     |
| Common Medical Event                                                                                                                                                                                                                                                      | Services You May Need                                                               | What You Will Pay                                                                                                                                                                                                    |                                                                                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                           |                                                                                     | In-Network Provider<br>(You will pay the least)                                                                                                                                                                      | Out-of-Network Provider<br>(You will pay the most)                                                                                                    |                                                                                                                                                                                                                                                     |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                                    | Primary care visit to treat an injury or illness                                    | \$20/visit                                                                                                                                                                                                           | Not covered                                                                                                                                           | -----none-----                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                                                    | \$35/visit                                                                                                                                                                                                           | Not covered                                                                                                                                           | Vision care (non-routine exam): \$35/visit for HMO-Network Providers.                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                           | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization           | No charge                                                                                                                                                                                                            | Not covered                                                                                                                                           | Vision screening: No charge for HMO-Network Providers.<br>You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                                                                                                                                                                                                                        | <a href="#">Diagnostic test</a> (x-ray, blood work)                                 | No charge                                                                                                                                                                                                            | Not covered                                                                                                                                           | -----none-----                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                                                        | \$100/procedure                                                                                                                                                                                                      | Not covered                                                                                                                                           | -----none-----                                                                                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br><small>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a></small>        | Tier 1 - Typically Generic                                                          | \$10/prescription (retail) and \$20/prescription (home delivery)                                                                                                                                                     | \$10/prescription (retail) plus 50% of the maximum <a href="#">allowed amount</a> , plus any costs above the maximum <a href="#">allowed amount</a> . | Most home delivery is 90-day supply.<br>*See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).                                                                                   |
|                                                                                                                                                                                                                                                                           | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | \$30/prescription (retail) and \$60/prescription (home delivery)                                                                                                                                                     | \$30/prescription (retail) plus 50% of the maximum <a href="#">allowed amount</a> , plus any costs above the maximum <a href="#">allowed amount</a> . |                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                           | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | \$60/prescription (retail) and \$120/prescription (home delivery)                                                                                                                                                    | \$60/prescription (retail) plus 50% of the maximum <a href="#">allowed amount</a> , plus any costs above the maximum <a href="#">allowed amount</a> . |                                                                                                                                                                                                                                                     |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

| Common Medical Event                                                      | Services You May Need                                            | What You Will Pay                                                                                                                                                    |                                                                | Limitations, Exceptions, & Other Important Information                                                                                                            |
|---------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                      | Out-of-Network Provider<br>(You will pay the most)             |                                                                                                                                                                   |
|                                                                           | Tier 4 - Typically <a href="#">Specialty</a> (brand and generic) | 20% <a href="#">coinsurance</a> up to a \$100 maximum /prescription (retail) and 20% <a href="#">coinsurance</a> up to a \$100 maximum /prescription (home delivery) | Not covered                                                    |                                                                                                                                                                   |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)                   | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                                           | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                              | \$75/visit                                                                                                                                                           | Covered as In- <a href="#">Network</a>                         | Copay waived if admitted. No charge for Emergency Room Physician Fee.                                                                                             |
|                                                                           | <a href="#">Emergency medical transportation</a>                 | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                                      | \$20/visit                                                                                                                                                           | Not covered                                                    | -----none-----                                                                                                                                                    |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                               | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                                           | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                              | Office Visit<br>\$20/visit<br>Other Outpatient<br>\$20/visit                                                                                                         | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----                                                                                              |
|                                                                           | Inpatient services                                               | No charge                                                                                                                                                            | Not covered                                                    | No charge for Inpatient Physician Fee In- <a href="#">Network Providers</a> . No coverage for Inpatient Physician Fee Out-of- <a href="#">Network Providers</a> . |
| If you are pregnant                                                       | Office visits                                                    | \$20/visit                                                                                                                                                           | Not covered                                                    | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).                                                                   |
|                                                                           | Childbirth/delivery professional services                        | No charge                                                                                                                                                            | Not covered                                                    |                                                                                                                                                                   |
|                                                                           | Childbirth/delivery facility services                            | No charge                                                                                                                                                            | Not covered                                                    |                                                                                                                                                                   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                                 | No charge                                                                                                                                                            | Not covered                                                    | -----none-----                                                                                                                                                    |
|                                                                           | <a href="#">Rehabilitation services</a>                          | No charge                                                                                                                                                            | Not covered                                                    | *See Therapy Services section                                                                                                                                     |
|                                                                           | <a href="#">Habilitation services</a>                            | No charge                                                                                                                                                            | Not covered                                                    |                                                                                                                                                                   |
|                                                                           | <a href="#">Skilled nursing care</a>                             | No charge                                                                                                                                                            | Not covered                                                    | 100 days limit/benefit period for In- <a href="#">Network Providers</a> .                                                                                         |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

| Common Medical Event                          | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                               |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
|                                               | <a href="#">Durable medical equipment</a> | No charge                                       | Not covered                                        | -----none-----                                         |
|                                               | <a href="#">Hospice services</a>          | No charge                                       | Not covered                                        | -----none-----                                         |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered                                     | Not covered                                        | *See Vision Services section                           |
|                                               | Children's glasses                        | Not covered                                     | Not covered                                        |                                                        |
|                                               | Children's dental check-up                | Not covered                                     | Not covered                                        | *See Dental Services section                           |

### 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
- Eye exams for a child
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (adult)
- Glasses for a child
- Private-duty nursing
- Weight loss programs
- Dental Check-up
- Long- term care
- Routine eye care/exam (adult)
- Infertility treatment

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion
- Acupuncture
- Hearing aids 1 every 36 months.
- Bariatric surgery
- Infertility treatment (Testing only)
- Chiropractic care 60 days limit/benefit period.

**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, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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:

ATTN: [Grievances](#) and [Appeals](#), PO Box 54159, Los Angeles, CA 90054-0159

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/>.

**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](#).

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

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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$35 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%   |
| ■ Other <a href="#">coinsurance</a>                             | 0%   |

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: |          |
| <a href="#">Cost Sharing</a>    |          |
| <a href="#">Deductibles</a>     | \$0      |
| <a href="#">Copayments</a>      | \$10     |
| <a href="#">Coinsurance</a>     | \$0      |
| <i>What isn't covered</i>       |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$70     |

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

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$35 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%   |
| ■ Other <a href="#">coinsurance</a>                             | 0%   |

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: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$0     |
| <a href="#">Copayments</a>      | \$1,700 |
| <a href="#">Coinsurance</a>     | \$0     |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$1,720 |

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

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$35 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%   |
| ■ Other <a href="#">coinsurance</a>                             | 0%   |

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: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$0     |
| <a href="#">Copayments</a>      | \$200   |
| <a href="#">Coinsurance</a>     | \$0     |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$200   |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 855-1950

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 855-1950 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 855-1950.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 855-1950:

**Bassa (Bàsɔ̀ wùdù):** M̐ dyi dyi-diè-djè b̐é b̐édjé b̐á céè-djè nià k̐e dyí ní, ɔ̀ m̐ò nì dyí-b̐édjèin-djè b̐é m̐ k̐é gbo-kpá-kpá k̐è b̐ǎ kp̐ǎ djé m̐ bídjí-wùdùùnn b̐ó pídyi. B̐é m̐ k̐é wuɖu-zìin-nyò d̐ò gbo wùdù k̐e, d̐á (844) 855-1950.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 855-1950 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (844) 855-1950 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 855-1950。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin col (844) 855-1950.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 855-1950.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 855-1950 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 855-1950.

## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 855-1950.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 855-1950.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 855-1950.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 855-1950.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 855-1950 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 855-1950.

**Igbo (Igbo):** O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na okowa okwu kwuo okwu, kpọọ (844) 855-1950.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 855-1950.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 855-1950.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 855-1950

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 855-1950 にお電話ください。



## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (844) 855-1950 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 855-1950.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 855-1950 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັກກັບລ່າມແປພາສາ, ໃຫ້ໃບທາ (844) 855-1950.

**Navajo (Diné):** Dít naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjĩ bee níl hodoonih t'áadoo bááh ilínígóó.  
Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (844) 855-1950.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 855-1950

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 855-1950 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 855-1950 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 855-1950.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 855-1950.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਆਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 855-1950 'ਤੇ ਕਾਲ ਕਰੋ।

## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (844) 855-1950.

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 855-1950.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (844) 855-1950.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 855-1950.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 855-1950.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 855-1950.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (844) 855-1950 เพื่อพูดคุยกับล่าม

**Ukrainian (Українська):** якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (844) 855-1950.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (844) 855-1950 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 855-1950.

**(Yiddish) (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (844) 855-1950.

**Yoruba (Yorùbá):** Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọfẹ́fẹ́. Bá wa ògbùfọ́ kan sọrọ́, pe (844) 855-1950.

## Language Access Services:

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