




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/ca/aso>. 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 (800) 967-3015 to request a copy. For your Pharmacy benefits through Express-Scripts (Medco) go to [www.express-scripts.com](http://www.express-scripts.com) or call 1-877-554-3091.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250/person or \$500/family for In- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care <a href="#">Specialist Visit Preventive Care</a> for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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> ?	\$1,250/person or \$2,500/family for In- <a href="#">Network Providers</a> . Prescription (Only In-network Providers): \$5,350/person or \$10,700/family.	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> ?	Prescription Drug cost share out-of-network, any member prescription penalties (if applicable), <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> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, EPO. See <a href="http://www.anthem.com/ca/prism">www.anthem.com/ca/prism</a> or call (800) 967-3015 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 <a href="#">Out-of-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 <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$20/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	Not covered	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>Pharmacy OOPM</b>	Out of Pocket Maximum (OOPM)	\$5,350 Per Person/\$10,700 Per Family	Non-Network claims do not apply to the OOPM	Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Tier 1 - Typically Generic	\$5 Co-pay (retail) \$10 Co-pay (mail order)	\$5 Co-pay (retail) Not Covered for mail order scripts	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs.
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$10 Co-pay (retail) \$20 Co-pay (mail order)	\$10 Co-pay (retail) Not Covered for mail order script	For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.  Prior Authorization / Coverage Management programs may apply to some drugs
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$25 Co-pay (retail) \$50 Co-pay (mail order)	\$25 Co-pay (retail) Not Covered for mail order script	90 day supply for maintenance medication available through Express Scripts, Walgreens and CVS. Although 90 day supplies are encouraged, members may continue filling 30-day supplies of any medication at any in-network retail pharmacy without penalty; however the broad retail pharmacy network is limited to dispensing a 30-day supply.
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	20% to \$100 max	Not covered	Out of Pocket Maximum (OOPM) Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	Not covered	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	Not covered	Costs may vary by site of service.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250/admission, then 0% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	Copay waived if admitted. 0% <a href="#">coinsurance</a> for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$20/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	Not covered	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit <a href="#">deductible</a> does not apply Other Outpatient 0% <a href="#">coinsurance</a>	Office Visit Not covered Other Outpatient Not covered	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	0% <a href="#">coinsurance</a>	Not covered	0% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . No Coverage for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .
If you are pregnant	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	Not covered	100 visits/benefit period for In- <a href="#">Network Providers</a> .
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	Not covered	Costs may vary by site of service.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	Not covered	*See Therapy Services section.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	Not covered	100 days/benefit period for skilled nursing services for <a href="#">In-Network Providers</a> .
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

### 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](#).)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Long-term care</li> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Eye exams for a child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Pediatric)</li> <li>• Glasses for a child</li> <li>• Routine eye care (Adult)</li> </ul> |
|---|--|--|

### Pharmacy Benefit Exclusions

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Allergy Serums</li> <li>• Drugs used to promote or stimulate hair growth</li> <li>• Non-Federal Legend Drugs</li> <li>• Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual</li> <li>• ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age</li> <li>• ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over</li> <li>• ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over</li> </ul> | <ul style="list-style-type: none"> <li>• Biologicals</li> <li>• Blood or blood plasma products</li> <li>• Nutritional Supplements</li> <li>• Some or certain compounds are excluded</li> <li>• ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age</li> <li>• ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over</li> <li>• Certain formulary exclusions apply, for more information on this as well as the latest drug coverage please visit our website <a href="http://www.express-scripts.com">www.express-scripts.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Drugs used for cosmetic purposes</li> <li>• Insulin Pumps</li> <li>• Ostomy Supplies</li> <li>• ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age</li> <li>• ACA Preventive Meds Fluoride-Exception: covered for children 6 months through 5 years of age</li> <li>• ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years</li> <li>• ACA Preventive Meds – Statins Exception: Covered for adults 40-75 years of age</li> </ul> |
|---|---|--|

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

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

- Acupuncture 12 visits/benefit period
- Hearing aids 1 Item(s)/ear every 3 years.
- Bariatric surgery
- Infertility treatment
- Chiropractic care 30 visits/benefit period
- Private-duty nursing in a Home Setting only

**Other Pharmacy Benefit Inclusions**

- Specialty Drugs
- Insulin
- OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products)
- ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age
- ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over
- ACA Preventive Meds - Statins Exception: Covered for adults 40-75 years of age
- State Restricted Drugs
- Needles and Syringes
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- Vaccines
- Drugs to treat Impotency for males only age 18 and over
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- ACA Preventive Meds Fluoride -Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds HIV – Exception: Covered for Generic Only

**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 Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.ca.gov/>, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). 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, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.ca.gov/>

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

### 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 section.*

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

## 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$20	■ <a href="#">Specialist copayment</a>	\$20	■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$250	<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$200	<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$2,700	Limits or exclusions	\$4,300	Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,950</b>	<b>The total Joe would pay is</b>	<b>\$4,600</b>	<b>The total Mia would pay is</b>	<b>\$560</b>

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 1-888-254-2721

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር 1-888-254-2721 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 1-888-254-2721.

**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՝ 1-888-254-2721:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á 1-888-254-2721.

**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 1-888-254-2721 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု 1-888-254-2721 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1-888-254-2721。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl 1-888-254-2721.

**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 1-888-254-2721.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 تماس بگیرید.

## Language Access Services:

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**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 1-888-254-2721.

**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 1-888-254-2721.

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**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 1-888-254-2721.

**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 1-888-254-2721 ।

**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 1-888-254-2721.

**Igbo (Igbo):** O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo 1-888-254-2721.

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## Language Access Services:

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ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ1-888-254-2721 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura 1-888-254-2721.

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo bááh ilínígóó.  
Ata' halne'ígíí la' bich'ı́' hadeesdzih nínizingo kojı́' hodiılnih 1-888-254-2721.

**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 1-888-254-2721

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 bilbilla.

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## Language Access Services:

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**(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 1-888-254-2721.

**Yoruba (Yorùbá):** Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe 1-888-254-2721.

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