



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/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 (844) 230-3683 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,500/person or \$3,000/family for In- <a href="#">Network Providers</a> .<br>\$4,500/person or \$13,500/family for Non- <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</a> . <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . For more information see below.                                                     | 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> ? | \$3,500/person or \$7,000/family for In- <a href="#">Network Providers</a> .<br>\$10,500/person or \$31,500/family for Non- <a href="#">Network Providers</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> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and Non- <a href="#">Network Transplants</a> .                                                  | 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, Blue Open Access POS. See <a href="http://www.anthem.com">www.anthem.com</a> or call (844) 230-3683 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the provider bills. | 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<br>(You will pay the least)                                                                                                         | Non-Network Provider<br>(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                          | \$30/visit <a href="#">deductible</a> does not apply                                                                                                    | 50% <a href="#">coinsurance</a>                                                           | Virtual visits (Telehealth) benefits available.                                                                                                                                               |
|                                                                                                                                                                                                                                                      | <a href="#">Specialist</a> visit                                          | \$70/visit <a href="#">deductible</a> does not apply                                                                                                    | 50% <a href="#">coinsurance</a>                                                           | Virtual visits (Telehealth) benefits available.                                                                                                                                               |
|                                                                                                                                                                                                                                                      | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization | No charge                                                                                                                                               | 30% <a href="#">coinsurance</a>                                                           | 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)                       | \$70/visit <a href="#">deductible</a> does not apply                                                                                                    | 50% <a href="#">coinsurance</a>                                                           | -----none-----                                                                                                                                                                                |
|                                                                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                                              | 0% <a href="#">coinsurance</a>                                                                                                                          | 50% <a href="#">coinsurance</a>                                                           | -----none-----                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> | Tier 1a - Typically Lower Cost Generic                                    | \$5/prescription, <a href="#">deductible</a> does not apply (retail) and \$13/prescription, <a href="#">deductible</a> does not apply (home delivery)   | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only) | For more information, refer to “Essential Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br>*See Prescription Drug section |
|                                                                                                                                                                                                                                                      | Tier 1b - Typically Generic                                               | \$20/prescription, <a href="#">deductible</a> does not apply (retail) and \$50/prescription, <a href="#">deductible</a> does not apply (home delivery)  | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only) |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                      | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs          | \$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$150/prescription, <a href="#">deductible</a> does not apply (home delivery) | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only) |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                      | Tier 3 - Typically Non-Preferred Brand and Generic drugs                  | \$85/prescription, <a href="#">deductible</a> does not apply (retail) and \$255/prescription, <a href="#">deductible</a> does not apply (home delivery) | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only) |                                                                                                                                                                                               |

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

| 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)                                                                            | Non-Network Provider<br>(You will pay the most)                                                        |                                                                                                       |
|                                                                           | Tier 4 - Typically Preferred Specialty (brand and generic) | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail and home delivery)                     | 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)              |                                                                                                       |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)             | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                        |
|                                                                           | Physician/surgeon fees                                     | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                        |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                        | \$350/visit                                                                                                                | 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>                                                                 | Non-emergency non- <a href="#">network</a> Ambulance Services are limited to \$50,000 per trip.       |
|                                                                           | <a href="#">Urgent care</a>                                | \$75/visit <a href="#">deductible</a> does not apply                                                                       | 50% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                        |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                         | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | 60 days/year for Inpatient rehabilitation and skilled nursing services combined.                      |
|                                                                           | Physician/surgeon fees                                     | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                        | Office Visit<br>\$30/visit <a href="#">deductible</a> does not apply<br>Other Outpatient<br>0% <a href="#">coinsurance</a> | Office Visit<br>50% <a href="#">coinsurance</a><br>Other Outpatient<br>50% <a href="#">coinsurance</a> | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none----- |
|                                                                           | Inpatient services                                         | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                        |
| If you are pregnant                                                       | Office visits                                              | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).       |
|                                                                           | Childbirth/delivery professional services                  | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        |                                                                                                       |
|                                                                           | Childbirth/delivery facility services                      | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        |                                                                                                       |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                           | 0% <a href="#">coinsurance</a>                                                                                             | 50% <a href="#">coinsurance</a>                                                                        | 120 visits/year.                                                                                      |
|                                                                           | <a href="#">Rehabilitation services</a>                    | \$30/visit <a href="#">deductible</a> does not apply                                                                       | 50% <a href="#">coinsurance</a>                                                                        | *See Therapy Services section.                                                                        |
|                                                                           | <a href="#">Habilitation services</a>                      | \$30/visit <a href="#">deductible</a> does not apply                                                                       | 50% <a href="#">coinsurance</a>                                                                        |                                                                                                       |

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

| 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) | Non-Network Provider<br>(You will pay the most) |                                                                                  |
|                                               | <a href="#">Skilled nursing care</a>      | 0% <a href="#">coinsurance</a>                  | 50% <a href="#">coinsurance</a>                 | 60 days/year for Inpatient rehabilitation and skilled nursing services combined. |
|                                               | <a href="#">Durable medical equipment</a> | 0% <a href="#">coinsurance</a>                  | 50% <a href="#">coinsurance</a>                 | *See <a href="#">Durable Medical Equipment</a> Section                           |
|                                               | <a href="#">Hospice services</a>          | 0% <a href="#">coinsurance</a>                  | 50% <a href="#">coinsurance</a>                 | -----none-----                                                                   |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered                                     | Not covered                                     | -----none-----                                                                   |
|                                               | Children's glasses                        | Not covered                                     | Not covered                                     |                                                                                  |
|                                               | Children's dental check-up                | Not covered                                     | Not covered                                     |                                                                                  |

### 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>• Acupuncture</li> <li>• Dental care (Adult)</li> <li>• Eye exams for a child</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Pediatric)</li> <li>• Glasses for a child</li> <li>• Long-term care</li> <li>• Routine foot care unless <a href="#">medically necessary</a></li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Hearing aids</li> <li>• Private-duty nursing</li> <li>• Spinal Manipulation</li> </ul> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

- Most coverage provided outside the United States. See [www.bcbglobalcore.com](http://www.bcbglobalcore.com)

**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), or contact Anthem at the number on the back of your ID card. 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 on how 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:

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

ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449

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

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)

**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.*

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">copayment</a>                               | \$70    |

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>  | \$1,500 |
| <a href="#">Copayments</a>   | \$700   |
| <a href="#">Coinsurance</a>  | \$0     |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$60    |
| The total Peg would pay is   | \$2,260 |

### 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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">copayment</a>                               | \$70    |

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>   | \$1,800 |
| <a href="#">Coinsurance</a>  | \$0     |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$20    |
| The total Joe would pay is   | \$1,820 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">copayment</a>                               | \$70    |

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>  | \$1,500 |
| <a href="#">Copayments</a>   | \$400   |
| <a href="#">Coinsurance</a>  | \$0     |
| <i>What isn't covered</i>    |         |
| Limits or exclusions         | \$0     |
| The total Mia would pay is   | \$1,900 |

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) 230-3683

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 230-3683 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) 230-3683.

**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) 230-3683:

**Bassa (Bàsɔ̀ Wùdù):** M̐ dyi dyi-diè-djé bɛ́ bédé b́á céè-djé nià kɛ́ dyí ní, ɔ̀ m̀b̀è nì dyí-bédjèin-djé bɛ́ m̀ kɛ́ gbo-kpá-kpá kè b̌́ kp̌́ djé m̀ b́ídjí-wùdùùnn b́ó pídyi. B́é m̀ kɛ́ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ́, d́á (844) 230-3683.

**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) 230-3683 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (844) 230-3683 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) 230-3683。

**Dinka (Dinka):** Na n̄ɔŋ thiēc 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 c̄ol (844) 230-3683.

**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) 230-3683.

**Farsi (فارسی):** 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 (844) 230-3683 تماس بگیرید.

## Language Access Services:

**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) 230-3683.

**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) 230-3683.

**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) 230-3683.

**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) 230-3683.

**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) 230-3683.

**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) 230-3683 ।

**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) 230-3683.

**Igbo (Igbo):** O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 230-3683.

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## Language Access Services:

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**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) 230-3683.

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັກກັບລາມແປພາສາ, ໃຫ້ໂທຫາ (844) 230-3683.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níł hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiilnih (844) 230-3683.

**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) 230-3683

**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) 230-3683 bilbilla.

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**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 ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (844) 230-3683 ਤੇ ਕਾਲ ਕਰੋ।

## Language Access Services:

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