



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/ or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$500/person or \$1,500/family for In-Network Providers. \$1,500/person or \$4,500/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your <u>deductible</u>?	Yes. Primary Care. Specialist Visit . Preventive Care . Certain Prescription Drugs . Vision Exam. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$4,000/person or \$8,000/family for In-Network Providers. \$12,000/person or \$24,000/family for Out-of-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the <u>out-of-pocket limit</u>?	Pre-Authorization Penalties, Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.anthem.com/find-care/?alphaprefix=JPU or call (855) 333-5730 for a list of network providers . Costs may	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an Out-of-Network Provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.

	vary by site of service and how the <u>provider</u> bills.	
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30/visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$50/visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$800 maximum/service for <u>Out-of-Network Providers</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.anthem.com/pharmacyinformation/	Typically Lower Cost Generic (Tier 1a)	\$5/prescription, <u>deductible</u> does not apply (retail) and \$10/prescription, <u>deductible</u> does not apply (home delivery)	50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery)	Most home delivery is 90-day supply. For more information, refer to "CA Essential DMHC Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section of the <u>plan</u> or policy document (e.g. evidence of coverage or certificate).
	Typically Generic (Tier 1b)	\$15/prescription, <u>deductible</u> does not apply (retail) and \$30/prescription, <u>deductible</u> does not apply (home delivery)	50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery)	
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$30/prescription, <u>deductible</u> does not apply (retail) and \$75/prescription, <u>deductible</u> does not apply (home delivery)	50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$50/prescription, <u>deductible</u> does not apply (retail) and \$125/prescription, <u>deductible</u>	50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u>	

* For more information about limitations and exceptions, see the 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		does not apply (home delivery)	does not apply (retail) and Not covered (home delivery)	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	30% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail and home delivery)	50% <u>coinsurance</u> up to \$250/prescription, <u>deductible</u> does not apply (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$350 maximum/admission for <u>Out-of-Network Providers</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$150/visit, then 20% <u>coinsurance</u>	Covered as In- <u>Network</u>	<u>Copayment</u> waived if admitted. 20% <u>coinsurance</u> for Emergency Room Physician Fee.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Urgent care</u>	\$30/visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$500 penalty if <u>Out-of-Network preauthorization</u> is not obtained. \$1,000 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> . 150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit, <u>deductible</u> does not apply Other Outpatient 20% <u>coinsurance</u>	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	Office Visit 988 lifeline/mobile crisis team covered as In- <u>Network</u> . Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$1,000 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> . 20% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network Providers</u> . 40% <u>coinsurance</u> for Inpatient Physician Fee <u>Out-of-Network Providers</u> .
If you are pregnant	Office visits	\$30/visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	\$1,000 maximum/day for Non-Emergency Admissions to <u>Out-of-Network Providers</u> . 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 visits/benefit period.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	\$0 <u>copayment</u> up to plan's Maximum <u>Allowed Amount</u>	*See Vision Services section.
	Children's glasses	Not covered	Not covered	
	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.)

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/>.

- Glasses for a child
- Long-term care
- Weight loss programs
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes

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

- Acupuncture 20 visits/benefit period
- Private-duty nursing in a Home Setting only
- Bariatric surgery (In-Network)
- Routine eye care (Adult) 1 exam/benefit period
- Chiropractic care 30 visits/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 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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

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

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/>

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.ca.gov/>

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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,970

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

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 በነጻ የማግኘት መብት 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): M̐ dyi dyi-diè-djé b̐é b̐édjé b̐á céè-djé nià k̐e dyí ní, ɔ̀ m̐ò nì dyí-b̐édjéìn-djé b̐é m̐ k̐é gbo-kpá-kpá k̐é b̐ǎ kp̐ǎ djé m̐ b̐ídjí-wùdùùñ b̐ó pídyi. B̐é m̐ k̐é wuɖu-zìin-nyò d̐ò gbo wùdù k̐e, d̐á 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 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 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 (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 1-888-254-2721 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 1-888-254-2721.

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.

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 1-888-254-2721.

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 bür ü na ì nwere ajuju o bula gbasara akwukwo a, ì nwere ikike ìnweta enyemaka na ozi n'asusu gi na akwughì ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721

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 1-888-254-2721 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ 1-888-254-2721 ។

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

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-888-254-2721 로 문의하십시오.

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

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nı́ł hodoonih t'áadoo báááh ilínígóó. Ata' halne'ígíí lá' bich'ı́' hadeesdzih nínízingo 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 wajiin walqabaate gaffi kamiyyu 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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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 1-888-254-2721.

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 1-888-254-2721.

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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-888-254-2721 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 1-888-254-2721.

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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 todogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.

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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 1-888-254-2721.

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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.

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Language Access Services:

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