



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/ or call (855) 653-4066 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Certain <u>Prescription Drugs</u> . For more information see below. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | \$2,000/single or \$4,000/family for In-Network Providers. This plan has a separate Out-of-Pocket Maximum of \$2,500/single or \$5,000/family for In-Network Providers for Prescription Drugs. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | Services deemed not medically necessary by Medical Management and/or Anthem, Pharmacy Claims, <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. NJ Horizon Managed Care Network. See www.anthem.com/ca or call | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> |

| | | |
|--|--|--|
| | (855) 653-4066 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills. | pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$25/visit | Not covered | Virtual visits (Telehealth) benefits available. |
| | <u>Specialist</u> visit | \$35/visit | Not covered | Virtual visits (Telehealth) benefits available. |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | 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) | 15% <u>coinsurance</u> | Not covered | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 15% <u>coinsurance</u> | Not covered | -----none----- |
| 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 Generic (Tier 1) | \$10/prescription (retail) and \$20/prescription (home delivery) | Not covered (retail and home delivery) | Certain preventive medications (including certain contraceptives) are covered at No Charge. Most home delivery is 90-day supply. For more information, refer to "National Direct Plus Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate). |
| | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | \$25/prescription or 20% <u>coinsurance</u> , whichever is greater up to a \$50 maximum/prescription (retail) and \$50/prescription or 20% <u>coinsurance</u> , whichever is greater up to a \$100 maximum/prescription (home delivery) | Not covered (retail and home delivery) | |
| | Typically Non-Preferred Brand and Generic drugs (Tier 3) | \$50/prescription or 30% <u>coinsurance</u> , whichever is greater up to a \$100 maximum/prescription (retail) | Not covered (retail and home delivery) | |

* For more information about limitations and exceptions, see the 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) | Out-of-Network Provider (You will pay the most) | |
| | | and \$100/prescription or 30% <u>coinsurance</u> , whichever is greater up to a \$200 maximum/prescription (home delivery) | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 15% <u>coinsurance</u> | Not covered | Pre-authorization required |
| | Physician/surgeon fees | 15% <u>coinsurance</u> | Not covered | -----none----- |
| If you need immediate medical attention | <u>Emergency room care</u> | 15% <u>coinsurance</u> | Covered as In-Network | 15% <u>coinsurance</u> for Emergency Room Physician Fee. |
| | <u>Emergency medical transportation</u> | 15% <u>coinsurance</u> | Covered as In-Network | -----none----- |
| | <u>Urgent care</u> | \$50/visit | Not covered | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 15% <u>coinsurance</u> | Not covered | Pre-authorization required |
| | Physician/surgeon fees | No charge | Not covered | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit \$25/visit Other Outpatient 15% <u>coinsurance</u> | Office Visit Not covered Other Outpatient Not covered | Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none----- |
| | Inpatient services | 15% <u>coinsurance</u> | Not covered | 15% <u>coinsurance</u> for Inpatient Physician Fee, In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network. Pre-authorization required |
| If you are pregnant | Office visits | \$25/visit for the first visit, then 15% <u>coinsurance</u> | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | 15% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 15% <u>coinsurance</u> | Not covered | 120 visits/benefit period for Home Health and Private Duty Nursing combined for In-Network Providers. One visit equals 8 hours or less |

* For more information about limitations and exceptions, see the 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) | Out-of-Network Provider (You will pay the most) | |
| | <u>Rehabilitation services</u> | \$35/visit | Not covered | 60 visits each for Physical, Speech and Occupational therapy combined/benefit period for In-Network Providers. Habilitation visits count towards your rehabilitation limit. *See Therapy Services section. |
| | <u>Habilitation services</u> | \$35/visit | Not covered | |
| | <u>Skilled nursing care</u> | 15% coinsurance | Not covered | |
| | <u>Durable medical equipment</u> | 15% coinsurance | Not covered | |
| | <u>Hospice services</u> | 15% coinsurance | Not covered | |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | *See Vision Services Section. |
| | 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.)

- Bariatric surgery
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Children's dental check-up
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Long-term care
- Weight loss programs

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
- Infertility treatment \$10,000 maximum /lifetime for artificial insemination and ovulation induction
- Chiropractic care 20 visits/benefit period
- Private-duty nursing 120 visits/benefit period combined with Home Health. One visit equals 8 hours or less.
- Hearing aids 1 every 36 months/pair up to \$5,000 maximum.
- Routine eye care (Adult)

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

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.dmhc.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: Grievance and Appeals, P.O. Box 54159, Los Angeles, CA 90054-0519

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

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.dmhc.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 overall deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$35 |
| ■ <u>Hospital (facility) coinsurance</u> | 15% |
| ■ <u>Other coinsurance</u> | 15% |

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:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,500 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,570 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|------|
| ■ The <u>plan's overall deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$35 |
| ■ <u>Hospital (facility) coinsurance</u> | 15% |
| ■ <u>Other coinsurance</u> | 15% |

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:

Cost Sharing

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$800 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,220 |

Mia's Simple Fracture

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

| | |
|--|------|
| ■ The <u>plan's overall deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$35 |
| ■ <u>Hospital (facility) coinsurance</u> | 15% |
| ■ <u>Other coinsurance</u> | 15% |

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:

Cost Sharing

| | |
|--------------------|-------|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$300 |

What isn't covered

| | |
|-----------------------------------|--------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$600 |

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): አለሁ ሰነድ ማንኛውም ብቻ ከለዋቸው በፈለም ቁንቁ እርዳታ እና ይህን መረጃ በለን የማንኛውም መሰት አለዋቸው:: አስተርጓሚ ለማንኛው 1-888-254-2721 ይደማል::

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 (Basa Wùqdù): M dyi dyi-diè-dé bá bédé bá céè-dé nià ke dyí ní, o mò nì dyí-bédéin-dé bá m ká gbo-kpá-kpá ká bá kpá dé m bídí-wùqdùún bá pídyi. Bé m ká wuqu-zìin-nyò dò gbo wùqdù ke, qá 1-888-254-2721.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য 1-888-254-2721 -তে কল করুন।

Burmese (မြန်မာ): ဤတရုပ်တတ်နှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြန်ရန် ဖြစ် 1-888-254-2721 ခို့ 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 nɔj thiéec nē ke de yā thoré, ke yin nɔj loj bē yi kuony ku wər aléu bē gəer yic yin ne thoj du ke cin wēu tääüe ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin col 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 هزینه ای 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 दस्तावेज 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 bụr ụ na ị nwere ajụụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkowa okwu kwuo okwu, kpọọ 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): បើមុកមានសំណូរឡើងទៅគម្រោគសារនេះ មុកមានសិទ្ធិទន្លេលដែនូយនិងកំមានជាការបស់មុកដោយគគិតគ្នា។ ធីមីជិតផែកជាមុកបាក់ប្រា ស្រុមហ៊ោ 1-888-254-2721 ១

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata gicro. 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): ທ່ານມີຄໍາຖາມໃດໆກ່ອນກັບພາກສານນີ້, ທ່ານມີສິດໄດ້ກັບຄວາມຮ່ວມຫຼື້ນ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ແລ້ວ. ເພື່ອໄຫວ້ມີກັບໜ້າ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos biká'ígíí ɬahgo bina'ídílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bázh ilníg óó. Ata' halne'ígíí ɬa' bich'í' hadeesdzih nínízingo kojí' hodíílnih 1-888-254-2721.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफै 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 wajiiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeefanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-888-254-2721 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 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 ਦੂਡਾਸ਼ੀਏ 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 totogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.

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

Thai (ไทย): หากท่านมีคำถามใดๆ ก็ได้กับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-888-254-2721 เพื่อพูดคุยกับล่าม

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 1-888-254-2721.

Yiddish (אידיש): אויב אויר האט שאלות וועגן דעם דאָקָומָעַנט, האט אויר די רעכט צו באָקָומָעַנט דעם אַנְפָאַרְמָאַצְיָע אַיִן אַיִיר שְׁפָרָאַךְ אַהֲן קִיִּין פֿרִיִּין. צו רעדן צו אַיִבְעַדְעַצְעַר, רופֵט 1-888-254-2721.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí iiberé nípa àkóṣílè yí, o ní ètò láti gba ìrànwó àti ìwífún ní èdè rẹ lófẹ́. Bá wa ògbùfò kan sòrò, pe 1-888-254-2721.

Language Access Services:

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