



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$300/person or \$600/family for <a href="#">Preferred Network Providers</a> . \$750/person or \$1,500/family for In- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care. <a href="#">Specialist</a> Visit. <a href="#">Preventive Care</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> ?	Medical: \$1,500/person or \$4,500/family for <a href="#">Preferred Network Providers</a> . \$1,500/person or \$4,500/family for In- <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.  See Pharmacy for the out-of-pocket-limit.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, California Care HMO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how	You pay the least if you use a <a href="#">provider</a> in <a href="#">Preferred Network</a> . You pay more if you use a <a href="#">provider</a> in In- <a href="#">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-</a>

	the provider bills.	<a href="#">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>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



All [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
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$35/visit <a href="#">deductible</a> does not apply	\$45/visit <a href="#">deductible</a> does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	\$10/visit <a href="#">deductible</a> does not apply	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100/service <a href="#">deductible</a> does not apply	\$100/service	Not covered	-----none-----
If you need drugs to treat your illness or condition Please call MedImpact member services at 800-788-2949 for more information	Tier 1 - Generic	Same as In-Network Provider	Other than Walgreens: Retail: \$10 copay Mail Order & Retail 90: \$25 copay	Not covered	Carved out to Med Impact.  Retail: Up to a 30 day supply, Mail Order and Retail 90: Up to a 90 day supply, Specialty drugs are available for up to a 30 day supply. Certain drugs may have a pre-notification or quantity per

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
about prescription drug coverage.			Walgreens: Retail: \$30 copay Retail 90: \$75		<p>prescription limitation. If you select a Brand drug when there is a generic equivalent available, you will be required to pay the cost plus the difference between the generic and the brand. Certain medications mandated by the Affordable Care Act are covered at no charge. Not all drugs are covered. Your specialty copay could be lowered if you are eligible to enroll in applicable pharmacy programs – check with your benefits department.</p> <p>Pharmacy for the out-of-pocket-limit - \$6,100/person or \$11,700/family for Preferred Network Providers. \$6,100/person or \$11,700/family for In-Network Providers.</p>
	Tier 2 - Preferred Brand	Same as In-Network Provider	Other than Walgreens: Retail: 25% coinsurance (\$25 minimum / \$75 maximum) Mail Order & Retail 90: 25% coinsurance (\$65 minimum / \$195 maximum)  Walgreens: Retail: 25% coinsurance (\$45 minimum / \$135 maximum) Mail Order: Not covered Retail 90: 25% coinsurance (\$115 minimum / \$345 maximum)	Not covered	
	Tier 3 - Non-Preferred Brand	Same as In-Network Provider	Other than Walgreens: Retail: 40% coinsurance (\$40 minimum / \$120 maximum) Mail Order & Retail 90:	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
			40% coinsurance (\$100 minimum / \$300 maximum)  Walgreens: Retail: 40% coinsurance (\$60 minimum / \$180 maximum) Mail Order: Not covered Retail 90: 40% coinsurance (\$150 minimum / \$450 maximum)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100/visit	\$100/visit	Not covered	-----none-----
	Physician/surgeon fees	No charge	No charge	Not covered	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit <a href="#">deductible</a> does not apply	\$250/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Copay waived if admitted. No charge for Emergency Room Physician Fee <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> .
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$20/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100/day up to 3 days/admission	\$200/day up to 3 days/admission	Not covered	-----none-----
	Physician/surgeon fees	No charge	No charge	Not covered	-----none-----

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit \$20/visit <a href="#">deductible</a> does not apply Other Outpatient No charge	Office Visit \$20/visit <a href="#">deductible</a> does not apply Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	\$100/day up to 3 days/admission	\$200/day up to 3 days/admission	Not covered	No charge for Inpatient Physician Fee <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> . No Coverage for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .
<b>If you are pregnant</b>	Office visits	\$20/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Not covered	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	No charge	No charge	Not covered	
	Childbirth/delivery facility services	\$100/day up to 3 days/admission	\$200/day up to 3 days/admission	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Not covered	100 visits/benefit period for <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	\$30/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Not covered	*See Therapy Services section.
	<a href="#">Habilitation services</a>	\$30/visit <a href="#">deductible</a> does not apply	\$30/visit <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	100 days/benefit period for skilled nursing services for <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	No charge	No charge	Not covered	-----none-----

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

#### Excluded Services & Other Covered Services:

Services Your **Plan** Generally Does NOT Cover (Check your policy or **plan** document for more information and a list of any other **excluded services**.)

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

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Hearing aids 1 item(s)/ear every 3 years</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care 60 days/benefit period combined with all other therapies</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing in a Home Setting only</li> </ul> |
|---|--|---|

**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.gov/>, 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:

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](http://www.dol.gov/ebsa/healthreform)

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

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.gov/>

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

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



## 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>	\$300
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$270</b>

### 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>	\$300
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,500</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$40
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$450</b>

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



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-888-254-2721

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ 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-djè bɛ́ bédjé bá céè-djè nià kɛ́ dyí ní, ɔ́ m̀b̀ nì dyí-bédjèin-djè bɛ́ m̀ kɛ́ gbo-kpá-kpá kè bɔ́ kpɔ́ djé m̀ bídí-wùdùùn b́ó pídýi. Bɛ́ m̀ kɛ́ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ́, d́á 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 nōŋ thiëc në ke de yā thorë, ke yin nōŋ loŋ bē yi kuony ku wër alëu bē gëer yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kōr yin ba jam wënë ran ye thok geryic, ke yin cōl 1-888-254-2721.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u 1-888-254-2721.

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

## Language Access Services:

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**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.

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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 bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

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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 1-888-254-2721.

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

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee níl hodoonih t'áadoo bááh ilínígóó.  
Ata' halne'ígíí la' 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 wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 bilbilla.

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## Language Access Services:

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## Language Access Services:

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