




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/ft>. 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 (833) 592-9956 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$500/person or \$1,000/family for In- <a href="#">Network Providers</a> .<br>\$1,000/person or \$2,000/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</a> Visit <a href="#">Preventive Care</a> for In- <a href="#">Network Providers</a> . Tier 1 Tier 2 Tier 3 Tier 4 <a href="#">Prescription Drugs</a> for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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> ? | \$4,000/person or \$8,000/family for In- <a href="#">Network Providers</a> .<br>\$8,000/person or \$16,000/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, 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, HealthKeepers. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 592-9956 for a list of <a href="#">network</a>                                                                                                                                                                                                                        | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive                                                                                                                                                                                                                                                                                            |

|                                                                              |                            |                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | <a href="#">providers.</a> | 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 out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | 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)                                                                      |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                                               | Primary care visit to treat an injury or illness                                                  | \$25/visit <a href="#">deductible</a> does not apply                                                                                                    | 30% <a href="#">coinsurance</a>                                                                                      | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                      | <a href="#">Specialist</a> visit                                                                  | \$50/visit <a href="#">deductible</a> does not apply                                                                                                    | 30% <a href="#">coinsurance</a>                                                                                      | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                      | <a href="#">Preventive care</a> / <a href="#">screening</a> /<br>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. |
| If you have a test                                                                                                                                                                                                                                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)                                               | No charge                                                                                                                                               | 30% <a href="#">coinsurance</a>                                                                                      | Costs may vary by site of service.                                                                                                                                                        |
|                                                                                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                                                                      | 20% <a href="#">coinsurance</a>                                                                                                                         | 30% <a href="#">coinsurance</a>                                                                                      | Costs may vary by site of service.                                                                                                                                                        |
| If you need drugs to treat your illness or condition<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><br>Essential Drug List | Tier 1 - Typically Generic                                                                        | \$15/prescription, <a href="#">deductible</a> does not apply (retail) and \$38/prescription, <a href="#">deductible</a> does not apply (home delivery)  | 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery) | *See Prescription Drug section.                                                                                                                                                           |
|                                                                                                                                                                                                                                                                      | Tier 2 - Typically <a href="#">Preferred Brand</a> & Non- <a href="#">Preferred</a> Generic Drugs | \$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$125/prescription, <a href="#">deductible</a> does not apply (home delivery) | 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                      | Tier 3 - Typically Non- <a href="#">Preferred</a> Brand and Generic drugs                         | \$85/prescription, <a href="#">deductible</a> does not apply (retail) and \$213/prescription, <a href="#">deductible</a> does not apply (home delivery) | 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                      | Tier 4 - Typically <a href="#">Preferred Specialty</a> (brand and generic)                        | 20% <a href="#">coinsurance</a> up to \$250/prescription, <a href="#">deductible</a> does not apply (retail and                                         | 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery) |                                                                                                                                                                                           |

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

| 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)                                                        |                                                                                                 |
|                                                                           |                                                  | home delivery)                                                                                                              |                                                                                                        |                                                                                                 |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>                                                                                             | Covered as In- <a href="#">Network</a>                                                                 | -----none-----                                                                                  |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                             | Covered as In- <a href="#">Network</a>                                                                 | -----none-----                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | \$50/visit <a href="#">deductible</a> does not apply                                                                        | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | 100 days/admission for Inpatient rehabilitation and skilled nursing services combined.          |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>\$25/visit <a href="#">deductible</a> does not apply<br>Other Outpatient<br>20% <a href="#">coinsurance</a> | Office Visit<br>30% <a href="#">coinsurance</a><br>Other Outpatient<br>30% <a href="#">coinsurance</a> | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----                            |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        |                                                                                                 |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        |                                                                                                 |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | 100 visits/benefit period.                                                                      |
|                                                                           | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | *See Therapy Services section                                                                   |
|                                                                           | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        |                                                                                                 |
|                                                                           | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | 100 days/admission for Inpatient rehabilitation and skilled nursing services combined.          |
|                                                                           | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | *See <a href="#">Durable Medical Equipment</a> Section                                          |
|                                                                           | <a href="#">Hospice services</a>                 | 20% <a href="#">coinsurance</a>                                                                                             | 30% <a href="#">coinsurance</a>                                                                        | -----none-----                                                                                  |
| If your child needs dental or eye care                                    | Children's eye exam                              | \$0/visit, <a href="#">deductible</a> does not apply                                                                        | Reimbursed Up to \$30                                                                                  | *See Vision Services section                                                                    |
|                                                                           | Children's glasses                               | Not covered                                                                                                                 | Not covered                                                                                            |                                                                                                 |

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

| 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) |                                                        |
|                      | Children's dental check-up | Not covered                                     | Not covered                                     | -----none-----                                         |

**Excluded Services & Other Covered Services:**

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

- |                                                                                                                                                         |                                                                                                                                                                                          |                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (Adult)</li> <li>• Glasses for a child</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Dental care (Pediatric)</li> <li>• Hearing aids</li> <li>• Routine foot care unless medically necessary</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Infertility treatment</li> <li>• Weight loss programs</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>• Chiropractic care 30 visits/benefit period</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing 100 visits/benefit period combined with Home Health</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: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945. 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 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 27401, Richmond, VA 23279

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

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

**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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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

## 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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ 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 | \$12,800 |
|--------------------|----------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$2,300        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,960</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ 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 | \$7,400 |
|--------------------|---------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$3,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,160</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$50  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| 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 | \$1,900 |
|--------------------|---------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,000</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 (833) 592-9956

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 592-9956 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 (833) 592-9956.

**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՝ (833) 592-9956:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè bɛ̀ bédé b́á céè-djè nià ke dyí ní, ɔ̀ mò ni dyí-bédjèin-djè b́é m̄ ké gbo-kpá-kpá kè b̄́ kp̄́ djé m̄ bídí-wùdùún b́ó pídyi. B́é m̄ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (833) 592-9956.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 592-9956 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833) 592-9956 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(833) 592-9956。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin col (833) 592-9956.

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