Your Summary of Benefits

Healthy Advantage PPO (HA PPO)

DEHIC
7/1/2024

Benefit	In-Network[1]	Out-of-Network[2,3]
Deductible	$0/$0	$500/$1,250
Coinsurance	10%	30%
Coinsurance Stop Loss	$2,500/$6,250 ($250/$625 out-of-pocket)	$3,000/$7,500 ($900/$2,250 out-of-pocket)
Out-of-Pocket Maximum	$5,080 individual / $12,700 family (All In-Network Medical & RX Cost Shares)	$1,400 individual / $3,500 family
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care[8]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0 copayment	Deductible and Coinsurance
Annual Physical Exam	$0 copayment	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0 copayment	Deductible and Coinsurance
Preventive Well-Woman Care	$0 copayment	Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits/Online Visits[1]	$30 copayment	Deductible and Coinsurance
Urgent Care Center	$30 copayment	$30 copayment
Emergency Room (initial visit per occurrence)	$50 copayment (Waived if admitted within 24 hours)	$50 copayment (Waived if admitted within 24 hours)
Routine Maternity Care	$30 copay first visit, Coinsurance all other visits/services	Deductible and Coinsurance
Allergy Care		
- Office Visit	$30 copayment	Deductible and Coinsurance
- Routine Testing	Coinsurance	Deductible and Coinsurance
- Allergy Injections/Immunotherapy	$0	Deductible and Coinsurance
Home Healthcare (Up to 365 visits per calendar year)	Coinsurance	Coinsurance (no deductible)
Home Infusion Therapy	Coinsurance	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	Coinsurance	Covered in-network only
Surgery[4], Presurgical Testing, Anesthesia	$30 copayment applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Deductible and Coinsurance
Chemotherapy, Radiation Therapy		Deductible and Coinsurance
Infertility Care		Deductible and Coinsurance
Laboratory Tests, X-rays		Deductible and Coinsurance
Vision Therapy		Covered in-network only
MRI[6], MRA[6], CAT Scan[6], PET[6] & Nuclear Cardiology[6]		Deductible and Coinsurance
Chiropractic Care[6]		Deductible and Coinsurance
Cardiac Rehabilitation (Unlimited visits per calendar year)		Deductible and Coinsurance
Second Surgical Opinion		Deductible and Coinsurance
Kidney Dialysis		Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network[1]**	**Member Pays Out-of-Network[2,3]**
Physical Therapy[4] (Unlimited visits per calendar year combined in home, office or outpatient facility)	$30 copayment applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Covered in-network only
Other Short-Term Rehabilitative Therapies – Speech/Language[4], Occupational[4] (Up to 30 visits per calendar year combined in home, office or outpatient facility)		Covered in-network only
Medical Chats and Virtual Visits for Primary Care (From our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device)*	$0 Copayment	Covered in-network only

*Anthem-enabled device refers to laptops/tablets/other devices where our app can be downloaded

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Inpatient Care[9]		
Inpatient Hospital (As many days as medically necessary; semiprivate room and board)	Coinsurance	Deductible and Coinsurance
Physical Therapy, Physical Medicine, Or Rehabilitation (Unlimited inpatient days per calendar year)	Coinsurance	Deductible and Coinsurance
Surgery, Surgical Assistant, Anesthesia	Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility (Up to 365 days per calendar year)	Coinsurance	Covered in-network only
Birthing Centers	Coinsurance	Covered in-network only
Mental Health		
Outpatient Visits in Office	$30 copay will apply to visit services (examinations and evaluations) in an office;; other services performed will be subject to In- Network coinsurance	Deductible and Coinsurance
Outpatient Visits in Facility	Coinsurance[7]	Deductible and Coinsurance
Inpatient Care[7,9] (As many days as medically necessary; semiprivate room and board)	Coinsurance	Deductible and Coinsurance
Alcohol/Substance Abuse		
Outpatient Visits in Office	$30 copay will apply to visit services (examinations and evaluations) in an office;; other services performed will be subject to In- Network coinsurance	Deductible and Coinsurance
Outpatient Visits in Facility	Coinsurance[7]	Deductible and Coinsurance
Inpatient Detoxification[7,9] (As many days as medically necessary; semiprivate room and board)	Coinsurance	Deductible and Coinsurance
Inpatient Rehabilitation[7,9]	Coinsurance	Deductible and Coinsurance
Other		
Medical Supplies	Coinsurance	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
Durable Medical Equipment[5]	Coinsurance	Covered in-network only
Prosthetics & Orthotics[5]	Coinsurance	Covered in-network only
Ambulance (Land/Air ambulance)	Coinsurance	In-network benefits apply
Prescription Drugs[10] Retail Program – One copayment required for up to a 30-day supply	$50 Deductible per person per calendar year Deductible does not apply to Tier 1 Generic drugs Tier 1/Tier 2/Tier 3 $10/$20/$40 copayment Includes Contraceptives (Retail & Mail-Order)	Covered in-network only
Mail-Order Program[11] – Only two copayments required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.	
Qualified Mail Order Service Options (Maintenance Medications)	**If you are taking a Maintenance Medication, you must select one of the qualified mail order service options through our Pharmacy Benefits Manager, CVS, or a DEHIC designated participating retail pharmacy. For new Maintenance Medication prescriptions, you may get the first 30 day supply and up to one additional 30 day refill of the Maintenance Medication at your local Retail Pharmacy. After that, you will need to select one of the qualified mail order service options to fill your prescription through the mail order supplier, CVS, or a designated participating pharmacy for maintenance drugs in order to realize the In-Network level of benefits.**	
Routine Vision Care - Please see separate Blue View Vision benefit summary for additional detail	$5 copay for 1 exam every 12 months $10 eyeglass lense copay $115 allowance then 20% off remaining balance for frames $75 allowance then 15 % off remaining balance for conventional contacts	$30 exam allowance $64 frame allowance $25-$45 eyeglass lense allowance

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(1) Network provider delivers care. The in-network office copayment applies to examinations and evaluations only. Other services performed at the office setting may be subject to in-network coinsurance. Anthem's network provider must precertify in-network services; Anthem's network providers cannot bill members beyond the copayment for covered services.
(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Anthem's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (7) for Mental Health and Alcohol/Substance Abuse Services.
(3) Out-of-network (O-O-N) providers – those who do not participate in Anthem's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Anthem or with another Blue Cross and Blue Shield Plan, may balance bill over Anthem's allowed amount. Precertification is not required for out-of-network services, nor from out-of-area in-network BlueCard® PPO provider service.
(4) You are responsible for obtaining precertification from Anthem's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, please call the toll-free number on your member ID card to determine exactly what outpatient services require pre-certification.
(5) For services received from an Anthem network provider, the provider must precertify in-network services; Anthem's PPO network providers cannot bill members beyond the co-payment, deductible, or coinsurance for covered services. Outside Anthem's network area, you or your provider must obtain precertification from Anthem's Medical Management Program for services from in-network BlueCard® PPO providers.
(6) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Anthem PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard® provider outside of Anthem's network area or out-of-network providers.
(7) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(8) Preventive Care benefits not subject to copayment and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(9) Network providers must obtain precertification from Anthem's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.Network providers must obtain precertification from Anthem's Medical Management Program for these services received from an out-of-area BlueCard PPO Provider.
(10) This prescription drug coverage meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.
(11) To receive a 90-day supply of prescription drugs through Anthem's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Anthem's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.Anthem.com/eocdps/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (844) 235-4455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/person or $0/family for In-Network Providers. $500/person or $1,250/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. Non-Network services require deductible. $50/person for retail Prescription Drugs for In-Network Providers. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$5,080/person or $12,700/family for In-Network Providers. $1,400/person or $3,500/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Blue Card PPO. See http://www.Anthem.com or call (844) 235-4455 for a list of network providers. Costs may vary by site of service and how	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider

	the provider bills.	for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	Non-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	$30/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	$30/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$30/visit for examinations and evaluations; 10% coinsurance for other services	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Penalties applied if precertification is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www11.Anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription, Prescription Drug deductible does not apply (retail) and $10/prescription (home delivery)	Not covered (retail and home delivery)	$50 per person per calendar year for In-Network Retail Prescription Drugs. Deductible does not apply to Tier 1 Generic drugs or Maintenance drugs obtained in a retail setting through the AMMO participating pharmacy. Retail – 1 copay required for up to a 30-day supply. Mail Order has the same copayments as retail, but only two copayments are required for a 90-day supply. Prior authorization may be required. For more information, refer to "National Drug List" at https://www11.Anthem.com
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$20/prescription, Prescription Drug deductible applies (retail) and $20/prescription (home delivery)	Not covered (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$40/prescription, Prescription Drug deductible applies (retail) and $40/prescription (home delivery)	Not covered (retail and home delivery)	

* 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				/pharmacyinformation/ *See Prescription Drug section If you are taking a Maintenance Medication, you must select one of the qualified mail order service options.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30/visit	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Penalties applied if precertification is not obtained
If you need immediate medical attention	Emergency room care	$50/visit	Covered as In-Network	Copay waived if admitted within 24 hours.
	Emergency medical transportation	10% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$30/visit	$30/visit deductible does not apply	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalties applied if precertification is not obtained.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $30/visit Other Outpatient 10% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Penalties applied if precertification is not obtained. Other Outpatient Penalties applied if precertification is not obtained.
	Inpatient services	10% coinsurance	30% coinsurance	Penalties applied if precertification is not obtained.
If you are pregnant	Office visits	$30/visit for the 1 visit, then 10% coinsurance	30% coinsurance	Penalties applied if precertification is not obtained. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

* 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance deductible does not apply	365 visits/benefit period.
	Rehabilitation services	10% coinsurance	Not covered	*See Therapy Services section.
	Habilitation services	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	365 days/benefit period for skilled nursing services for In-Network Providers.
	Durable medical equipment	10% coinsurance	Not covered	*See Durable Medical Equipment Section. Penalties applied if precertification is not obtained
	Hospice services	10% coinsurance	Not covered	210 days/lifetime for In-Network Providers.
If your child needs dental or eye care	Children's eye exam	$5 copay	$30 allowance deductible does not apply.	*See Vision Services section.
	Children's glasses	Allowance/copay (see limitations & exceptions for detail).	$64 frame allowance deductible does not apply. $25-$45 eyeglass lens allowance deductible does not apply. $75 contact lens Allowance deductible does not apply.	
	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.)

- Cosmetic surgery
- Dental Check-up
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)
- Dental care (Pediatric)
- Long-term care
- Routine foot care

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Infertility treatment – certain services	• Bariatric surgery • Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Chiropractic care

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: New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, Mail Drop R/6-O, P.O. Box 11825, Albany, NY 12211

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

New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600

Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400, www.communityhealthadvocates.org, cha@cssny.org

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 plan's overall deductible	$0
Specialist *copayment*	$30
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	
Deductibles	$0
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *copayment*	$30
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	
Deductibles*	$50
Copayments	$1,100
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$30
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 235-4455

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 235-4455 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 235-4455 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 235-4455:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dɔ̀ gbo wùdù kɛ, dá (844) 235-4455.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 235-4455 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခွင့်အလမ်းများနှင့် အကူအညီကို အခမဲ့ကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (844) 235-4455 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 235-4455。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (844) 235-4455.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 235-4455.

Farsi (فارسي): 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 تماس بگیرید. (844) 235-4455

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 235-4455.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 235-4455.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 235-4455.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 235-4455.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 235-4455.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(844) 235-4455 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 235-4455.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 235-4455.

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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 (844) 235-4455.

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 (844) 235-4455

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Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(844) 235-4455 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 235-4455.

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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (844) 235-4455.

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Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 235-4455

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 235-4455 bilbilla.

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 235-4455.

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Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (844) 235-4455 ਤੇ ਕਾਲ ਕਰੋ।

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Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (844) 235-4455 **เพื่อพูดคุยกับล่าม**

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