



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/82LDIND01012025>. 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) 453-7031 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$75/person or \$150/family for In- <u>Network Providers</u> .                                                                                                                                                                                         | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Primary Care. <u>Preventive Care</u> . Certain <u>Prescription Drugs</u> . Vision. For more information see below.                                                                                                                                | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                    | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$1,100/person or \$2,200/family for In- <u>Network Providers</u> .                                                                                                                                                                                    | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                                                                                                      | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=X4X">www.anthem.com/find-care/?alphaprefix=X4X</a> or call (855) 453-7031 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

|                                                            |     |                                                                          |
|------------------------------------------------------------|-----|--------------------------------------------------------------------------|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
|------------------------------------------------------------|-----|--------------------------------------------------------------------------|

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                                                                                                                                                                                 | Services You May Need                                            | What You Will Pay                                                                                                                    |                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                      |                                                                  | Level 1 Pharmacy- RX Only<br>(You will pay the least)                                                                                | In-Network Provider<br>(You will pay more)                        | Out-of-Network Provider<br>(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                 | Not Applicable                                                                                                                       | \$15/visit, <u>deductible</u> does not apply                      | Not covered                                        | Virtual visits (Telehealth) benefits available.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                      | <u>Specialist</u> visit                                          | Not Applicable                                                                                                                       | 15% <u>coinsurance</u>                                            | Not covered                                        | Virtual visits (Telehealth) benefits available.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                      | <u>Preventive care</u> / <u>screening</u> /immunization          | Not Applicable                                                                                                                       | No charge                                                         | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                         |
| If you have a test                                                                                                                                                                                                                   | <u>Diagnostic test</u> (x-ray, blood work)                       | Not Applicable                                                                                                                       | 15% <u>coinsurance</u>                                            | Not covered                                        | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                                     | Not Applicable                                                                                                                       | 15% <u>coinsurance</u>                                            | Not covered                                        | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> | Typically Generic (Tier 1)                                       | \$5/prescription, <u>deductible</u> does not apply (retail) and \$15/prescription, <u>deductible</u> does not apply (home delivery)  | \$10/prescription, <u>deductible</u> does not apply (retail only) | Not covered (retail and home delivery)             | Precertification may be required for certain <u>Prescription Drugs</u> . Please note that certain <u>Specialty Drugs</u> are only available from the <u>Specialty Pharmacy</u> and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. For more information, refer to "Select Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br><u>Preventive Care</u> drugs are covered in full regardless of tier.<br>*See Prescription Drug section |
|                                                                                                                                                                                                                                      | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | \$30/prescription, <u>deductible</u> does not apply (retail) and \$90/prescription, <u>deductible</u> does not apply (home delivery) | \$45/prescription, <u>deductible</u> does not apply (retail only) | Not covered (retail and home delivery)             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                      | Typically Non-Preferred Brand and Generic drugs (Tier 3)         | \$60/prescription, <u>deductible</u> does not apply (retail) and                                                                     | \$75/prescription, <u>deductible</u> does not                     | Not covered (retail and home delivery)             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/82LDIND01012025>.

| Common Medical Event                                                      | Services You May Need                                             | What You Will Pay                                                               |                                                                                      |                                                                | Limitations, Exceptions, & Other Important Information                                                   |
|---------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
|                                                                           |                                                                   | Level 1 Pharmacy- RX Only (You will pay the least)                              | In-Network Provider (You will pay more)                                              | Out-of-Network Provider (You will pay the most)                |                                                                                                          |
|                                                                           |                                                                   | \$180/prescription, <u>deductible</u> does not apply (home delivery)            | apply (retail only)                                                                  |                                                                | of your evidence of coverage, available in the footnote below.                                           |
|                                                                           | Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4) | \$250/prescription, <u>deductible</u> does not apply (retail and home delivery) | \$265/prescription, <u>deductible</u> does not apply (retail only)                   | Not covered (retail and home delivery)                         |                                                                                                          |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)                    | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Not covered                                                    | -----none-----                                                                                           |
|                                                                           | Physician/surgeon fees                                            | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Not covered                                                    | -----none-----                                                                                           |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                                        | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Covered as In-<br><u>Network</u>                               | -----none-----                                                                                           |
|                                                                           | <u>Emergency medical transportation</u>                           | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Covered as In-<br><u>Network</u>                               | Non-emergency Out-of-<br><u>Network</u> Ambulance Services are limited to \$50,000 per occurrence.       |
|                                                                           | <u>Urgent care</u>                                                | Not Applicable                                                                  | \$50/visit, <u>deductible</u> does not apply                                         | Covered as In-<br><u>Network</u>                               | -----none-----                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                                | Not Applicable                                                                  | 30% <u>coinsurance</u>                                                               | Not covered                                                    | 60 days/benefit period for Inpatient rehabilitation for In-<br><u>Network Providers</u> .                |
|                                                                           | Physician/surgeon fees                                            | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Not covered                                                    | -----none-----                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                               | Not Applicable                                                                  | Office Visit<br>15% <u>coinsurance</u><br>Other Outpatient<br>15% <u>coinsurance</u> | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | Office Visit<br>Virtual visits (Telehealth)<br>benefits available.<br>Other Outpatient<br>-----none----- |
|                                                                           | Inpatient services                                                | Not Applicable                                                                  | 30% <u>coinsurance</u>                                                               | Not covered                                                    | -----none-----                                                                                           |
| If you are pregnant                                                       | Office visits                                                     | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Not covered                                                    | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).         |
|                                                                           | Childbirth/delivery professional services                         | Not Applicable                                                                  | 15% <u>coinsurance</u>                                                               | Not covered                                                    |                                                                                                          |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/82LDIND01012025>.

| Common Medical Event                                           | Services You May Need                 | What You Will Pay                                     |                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                          |
|----------------------------------------------------------------|---------------------------------------|-------------------------------------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                       | Level 1 Pharmacy- RX Only<br>(You will pay the least) | In-Network Provider<br>(You will pay more)   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                 |
|                                                                | Childbirth/delivery facility services | Not Applicable                                        | 30% <u>coinsurance</u>                       | Not covered                                        |                                                                                                                                                                                 |
| If you need help recovering or have other special health needs | <u>Home health care</u>               | Not Applicable                                        | 15% <u>coinsurance</u>                       | Not covered                                        | 28 hours/week for Home Health and Private Duty Nursing combined for In- <u>Network Providers</u> .                                                                              |
|                                                                | <u>Rehabilitation services</u>        | Not Applicable                                        | \$15/visit, <u>deductible</u> does not apply | Not covered                                        | 20 visits each for Physical, Speech and Occupational therapy/benefit period for In- <u>Network Providers</u> .                                                                  |
|                                                                | <u>Habilitation services</u>          | Not Applicable                                        | \$15/visit, <u>deductible</u> does not apply | Not covered                                        | 20 visits each for Physical, Speech and Occupational therapy/benefit period for In- <u>Network Providers</u> .                                                                  |
|                                                                | <u>Skilled nursing care</u>           | Not Applicable                                        | 15% <u>coinsurance</u>                       | Not covered                                        | 100 days/benefit period for skilled nursing services for In- <u>Network Providers</u> .                                                                                         |
|                                                                | <u>Durable medical equipment</u>      | Not Applicable                                        | 15% <u>coinsurance</u>                       | Not covered                                        | *See <u>Durable Medical Equipment</u> section.                                                                                                                                  |
|                                                                | <u>Hospice services</u>               | Not Applicable                                        | 15% <u>coinsurance</u>                       | Not covered                                        | -----none-----                                                                                                                                                                  |
|                                                                |                                       |                                                       |                                              |                                                    |                                                                                                                                                                                 |
| If your child needs dental or eye care                         | Children's eye exam                   | Not Applicable                                        | No charge                                    | Not covered                                        | Coverage is limited to 1 exam per benefit period for In- <u>Network Providers</u> . *See Vision Services section of your evidence of coverage, available in the footnote below. |
|                                                                | Children's glasses                    | Not Applicable                                        | No charge                                    | Not covered                                        | Coverage is limited to 1 unit per benefit period for In- <u>Network Providers</u> . *See Vision Services section of your evidence of coverage, available in the footnote below. |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/82LDIND01012025>.

| Common Medical Event | Services You May Need      | What You Will Pay                                  |                                         |                                                 | Limitations, Exceptions, & Other Important Information                           |
|----------------------|----------------------------|----------------------------------------------------|-----------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------|
|                      |                            | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) |                                                                                  |
|                      | Children's dental check-up | Not Applicable                                     | 0% <u>coinsurance</u>                   | Not covered                                     | Coverage is limited to 2 visits per 12 months for In- <u>Network Providers</u> . |

#### 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
- Long-term care
- Routine foot care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Hearing aids (18+)
- Routine eye care (Adult)

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

- Abortion (including Non-Hyde Abortion Services)
- Chiropractic care 20 visits/benefit period
- Acupuncture 6 visits/benefit period
- Infertility treatment
- Bariatric surgery
- Private-duty nursing Facility Setting no limit and 28 hours/week combined with Home Health

**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: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490, 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, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/82LDIND01012025>.

**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? Not Applicable.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$75 |
| ■ <u>Specialist coinsurance</u>               | 15%  |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%  |
| ■ Other <u>coinsurance</u>                    | 15%  |

This **EXAMPLE** event includes services like:

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

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$75    |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$1,000 |
| <i>What isn't covered</i>  |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$1,135 |

### Managing Joe's Type 2 Diabetes

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

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$75 |
| ■ <u>Specialist coinsurance</u>               | 15%  |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%  |
| ■ Other <u>coinsurance</u>                    | 15%  |

This **EXAMPLE** event includes services like:

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

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$75    |
| <u>Copayments</u>          | \$1,000 |
| <u>Coinsurance</u>         | \$50    |
| <i>What isn't covered</i>  |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$1,120 |

### Mia's Simple Fracture

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

|                                               |      |
|-----------------------------------------------|------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$75 |
| ■ <u>Specialist coinsurance</u>               | 15%  |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%  |
| ■ Other <u>coinsurance</u>                    | 15%  |

This **EXAMPLE** event includes services like:

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

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>        |       |
|----------------------------|-------|
| <u>Deductibles</u>         | \$75  |
| <u>Copayments</u>          | \$70  |
| <u>Coinsurance</u>         | \$400 |
| <i>What isn't covered</i>  |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$545 |

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 (855) 453-7031

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 453-7031 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 (855) 453-7031.

**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՝ (855) 453-7031:

**Bassa (Bàsɔ̀ Wùdù):** M̐ dyi dyi-diè-djè b̐é b̐édjé b̐á céè-djè nià k̐e dyí ní, ɔ̀ m̐ò nì dyí-b̐édjèin-djè b̐é m̐ k̐é gbo-kpá-kpá k̐é b̐ǎ kpǎ djé m̐ b̐ídjí-wùdùùnn̐ b̐ó pídyi. B̐é m̐ k̐é wuɖu-zìin-nyò d̐ò gbo wùdù k̐e, d̐á (855) 453-7031.

**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 (855) 453-7031 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 453-7031 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(855) 453-7031。

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## Language Access Services:

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