




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, visit anthembluecross.com. 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 (800) 553-9603 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$750 Individual / \$1,500 Family <u>Out-of-Network</u> : \$5,000 Individual / \$12,500 Family; <u>Deductible</u> accumulates on a calendar year basis.	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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care</u> , optical and <u>prescription drugs</u> are covered before you meet your overall <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 Individual / \$100 Family for <u>prescription drugs</u> . <u>Deductible</u> accumulates on a calendar year basis. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	<u>In-Network</u> Medical and Hospital providers: \$5,350/person or \$10,700/family; <u>out-of-pocket limit</u> accumulates on a calendar year basis. <u>Out-of-Network</u> Medical and Hospital providers: None <u>In-Network</u> Prescription Drugs: \$1,300 Individual / \$2,600 Family; <u>out-of-pocket limit</u> accumulates on a calendar year basis. For <u>Out-of-Network</u> Prescription Drugs: Not Applicable.	<u>In-Network</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. <u>Out-of-Network</u> : This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your <u>Out-of-Network</u> expenses.
What is not included in the out-of-pocket limit?	Medical and Hospital: <u>Premiums</u> , <u>balance-billing</u> charges, outpatient <u>prescription drugs</u> , vision, and health care this <u>plan</u> doesn't cover. <u>Prescription Drugs</u> : <u>Premiums</u> , <u>balance-billing</u> charges, medical and hospital expenses, vision care expenses, your <u>cost sharing</u> and costs paid by drug	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

	manufacturers for certain non-essential <u>specialty drugs</u> , drugs and health care this <u>plan</u> doesn't cover.	
Will you pay less if you use a <u>network provider</u>?	Yes, PPO. See http://www.anthembluecross.com or call (800) 553-9603 for a list of <u>network providers</u> .	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. When required by law, a course of treatment by a terminating <u>provider</u> or facility may continue to be covered at the <u>In-Network</u> rate for up to 90 days if certain requirements are met. For more information about continuity of care, see the Summary <u>Plan</u> Description (SPD) and Summaries of Material Modifications (SMM) at www.local802afm.org/healthcare/ .
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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	Subject to age and frequency limits. 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. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Office and free-standing facility: 30% <u>coinsurance</u> ; Hospital outpatient: No charge	Office, free-standing facility and hospital outpatient: 50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 30% <u>coinsurance</u> ; Hospital outpatient: No charge	Office, free-standing facility and hospital outpatient: 50% <u>coinsurance</u>	None

* For more information about limitations and exceptions, see plan or policy document at anthembluecross.com.

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.expressscript.com.</p>	Generic drugs	Retail: \$20 <u>copay</u> /prescription Mail Order: \$40 <u>copay</u> /prescription	Retail: \$20 <u>copay</u> /prescription plus difference in cost between <u>Out-of-Network</u> pharmacy charges and <u>allowed amount</u> ; Mail Order: Not covered	<p>Medical <u>deductibles</u> do not apply; separate <u>prescription drug deductible</u> applies. <u>Prescription drug</u> benefit covers up to a 30-day supply for retail prescriptions and up to a 90-day supply for mail order prescriptions. Maintenance <u>prescription drugs</u> are limited to two retail fills and then must be filled through the mail order pharmacy. No charge for FDA-approved generic preventive medications and contraceptives (or brand name if a generic is medically inappropriate). Generic drugs are mandatory when available. If you fill a brand name drug when a generic equivalent is available, you will pay an additional amount equal to the difference between the <u>allowed amount</u> for the brand name and the generic medication. If you fill a prescription at an <u>Out-of-Network</u> pharmacy, you will pay an additional amount equal to the difference between the pharmacy's charges and the <u>allowed amount</u> for the medication. Mail order not covered <u>Out-of-Network</u>. Certain drugs are subject to clinical management programs, including <u>formulary</u> management, <u>preauthorization</u>, and/or step therapy criteria in order to be covered and/or there may be quantity limitations or exclusions. Non-<u>formulary</u> brand drugs are excluded and you must pay 100% of this cost, even <u>in-network</u>. *See the <u>Prescription Drug</u> section of the SPD and SMMs. Drugs administered in a doctor's office or compounded for IV infusion are not available by mail order. <u>Specialty drugs</u> must be ordered from Accredo mail order pharmacy. The SaveOnSP <u>Specialty Drug</u> List is available at www.saveonsp.com/local802afm. Your <u>cost sharing</u> for “non-essential” <u>specialty drugs</u>, as well as any amount paid by the drug manufacturer through its <u>copay</u> assistance program, do not count toward your <u>out-of-pocket limit</u>.</p>
	<u>Formulary</u> brand drugs	Retail: \$35 <u>copay</u> /prescription Mail Order: \$70 <u>copay</u> /prescription	Retail: \$35 <u>copay</u> /prescription plus difference in cost between <u>Out-of-Network</u> pharmacy charges and <u>allowed amount</u> Mail Order: Not covered	
	Non- <u>formulary</u> brand drugs	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
	<u>Specialty drugs</u>	Retail: Not covered Mail Order: 40% <u>coinsurance</u> (\$300 maximum/prescription) No cost for <u>specialty drugs</u> on the SaveOnSP <u>Specialty Drug</u> List if you enroll in that program. You pay the full <u>copay</u> indicated on that list if you do not enroll in that program.	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see [plan](#) or policy document at anthebluecross.com.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	Covered as In- <u>Network</u>	<u>Copay</u> waived if admitted to the hospital. Professional/physician charges may be billed separately, except as provided by the No Surprises Act. When required by law, <u>Out-of-Network emergency room care</u> will be treated as <u>In-Network</u> .
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	Covered as In- <u>Network</u>	Non-emergency <u>Out-of-Network</u> ambulance services covered at 50% <u>coinsurance</u> . When required by law, <u>Out-of-Network</u> air ambulance services will be treated as <u>In-Network</u>
	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	When required by law, <u>Out-of-Network emergency services</u> provided at <u>urgent care</u> facilities licensed in the state to provide emergency care will be treated as <u>In-Network</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Physician/surgeon fees	<u>Primary care physician</u> : \$30 <u>copay</u> /visit; <u>Specialist</u> : \$50 <u>copay</u> /visit; <u>Surgeon</u> : 30% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, <u>Out-of-Network</u> physician fees will be treated as <u>In-Network</u> .

* For more information about limitations and exceptions, see [plan](#) or policy document at anthembluecross.com.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$30 <u>copay</u> /visit; <u>deductible</u> does not apply Other outpatient services (partial <u>hospitalization</u> /intensive outpatient): 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Office Visit: Apply one <u>copay</u> per ongoing treatment. Virtual visits (Telehealth) benefits available. Other Outpatient: Apply one <u>copay</u> per ongoing treatment. <u>Preauthorization</u> is required for partial <u>hospitalization</u> and intensive outpatient programs. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Inpatient services	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>in-network preventive services</u> . Depending on the type of services and/or provider, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs. Notification is required for <u>Out-of-Network</u> admissions that exceed 48-hours for delivery (or 96-hours for C-sections).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year (combined <u>In/Out-of-Network</u>).
	<u>Rehabilitation services</u>	Office visit: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply Other outpatient services: 30% <u>coinsurance</u> Inpatient: \$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs. Outpatient maintenance speech and hearing therapy not covered.
	<u>Habilitation services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Outpatient maintenance speech and hearing therapy not covered.

* For more information about limitations and exceptions, see [plan](#) or policy document at anthembluecross.com.

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)	
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 <u>skilled nursing care</u> facility bed days/calendar year (combined <u>In/Out-of-Network</u>). <u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Hospice services	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Inpatient hospice coverage is limited to 210 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Amount over \$15 <u>plan</u> allowance	Amount over \$15 <u>plan</u> allowance	Medical <u>deductibles</u> do not apply. Does not count toward <u>out-of-pocket limit</u> . Vision benefits separately administered by General Vision Services and Vision <u>Screening</u> . Coverage limited to one eye exam/calendar year and one complete pair of glasses/calendar year. You are responsible for amounts over <u>plan</u> allowances.
	Children's glasses	Frames: Amount over \$11 <u>plan</u> allowance; Single vision lenses: Amount over \$13 <u>plan</u> allowance; Bifocals: Amount over \$19 <u>plan</u> allowance; Trifocals: Amount over \$24 <u>plan</u> allowance	Frames: Amount over \$11 <u>plan</u> allowance; Single vision lenses: Amount over \$13 <u>plan</u> allowance; Bifocals: Amount over \$19 <u>plan</u> allowance; Trifocals: Amount over \$24 <u>plan</u> allowance	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u>

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • <u>Non-formulary</u> prescription drugs • <u>Preauthorization</u> - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether <u>preauthorization</u> has been given. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs (Except for morbid obesity and as required for <u>preventive services</u> under the ACA)

* For more information about limitations and exceptions, see plan or policy document at anthembluecross.com.

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

- Acupuncture (Combined 50-visit limit/calendar year with chiropractic care and physical therapy)
- Bariatric Surgery
- Chiropractic care(Combined 50-visit limit/calendar year with acupuncture and physical therapy)
- Infertility treatment (Limited to diagnosis and treatment of correctable medical conditions that result in infertility)
- Routine eye care (Adult) (Limited to one eye exam/calendar year and one pair of glasses/calendar year)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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 anthembluecross.com.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$750	■ The <u>plan's</u> overall <u>deductible</u>	\$750	■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$50	■ <u>Specialist copayment</u>	\$50	■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$550	■ Hospital (facility) <u>copayment</u>	\$500	■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%
<p>This EXAMPLE event includes services like:</p> <p><u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$800	<u>Deductibles*</u>	\$800	<u>Deductibles*</u>	\$760
<u>Copayments</u>	\$510	<u>Copayments</u>	\$900	<u>Copayments</u>	\$590
<u>Coinsurance</u>	\$1,000	<u>Coinsurance</u>	\$50	<u>Coinsurance</u>	\$280
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,330	The total Joe would pay is	\$1,750	The total Mia would pay is	\$1,630

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

*NOTE: This plan has other deductibles for specific services included in this coverage example.
 See "Are there other deductibles for specific services?" row above.

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 (800) 553-9603

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (800) 553-9603 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 (800) 553-9603.

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՝ (800) 553-9603:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (800) 553-9603.

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 (800) 553-9603 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (800) 553-9603 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(800) 553-9603。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 553-9603.

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 (800) 553-9603.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 553-9603 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 553-9603.

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 (800) 553-9603.

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 (800) 553-9603.

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 (800) 553-9603.

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 (800) 553-9603.

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 (800) 553-9603 ।

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 (800) 553-9603.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (800) 553-9603.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 553-9603.

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 (800) 553-9603.

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 (800) 553-9603

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 553-9603 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 553-9603.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(800) 553-9603 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກັບວ່າມແປພາສາ, ໃຫ້ໂທຫາ (800) 553-9603.

Navajo (Diné): Dii naaltsoos bika'ígíí lahgo bina'idíilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojí' hodiilnih (800) 553-9603.

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 (800) 553-9603

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 553-9603 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 (800) 553-9603.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (800) 553-9603.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (800) 553-9603 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (800) 553-9603.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 553-9603.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se tofogi. Ina ia talanoa i se tagata faaliliu, vili (800) 553-9603.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (800) 553-9603.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 553-9603.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (800) 553-9603 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (800) 553-9603.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (800) 553-9603 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (800) 553-9603.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (800) 553-9603.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (800) 553-9603.

Language Access Services:

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