




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/SH08012022L00548>. 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 844-412-0752 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$200/student for In- Network Providers (University of Louisville Healthcare).\$700 for In- Network Providers . \$1,000/student 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 ? | Yes. Primary Care Specialist Visit for In- Network , In- Network and Non- Network Providers . Preventive Care for In- Network and In- Network Providers . Tier 1 Tier 2 Tier 3 Prescription Drugs for In- Network , In- Network and Non- Network Providers . Vision for In- Network and Non- Network Providers . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$5,000/person or \$10,000/family for U of L and In- Network Providers . \$5,000/person or \$10,000/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. |

| | | |
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| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges, health care this plan doesn't cover, and Non- Network Transplants. | 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 Access. See https://www.anthem.com/health-insurance/provider-directory/searchcriteria?planstate=KY&plantype=NETWORK&planname=Blue+Access or call 844-412-0752 for a list of network providers . | You pay the least if you use a provider in In- Network . You pay more if you use a provider in In- 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 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) | In- Network Provider (You will pay more) | 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 then 10% coinsurance deductible does not apply | \$30/visit then 30% coinsurance deductible does not apply | \$30/visit then 35% coinsurance deductible does not apply | -----none----- |
| | Specialist visit | \$30/visit then 10% coinsurance deductible does not apply | \$30/visit then 30% coinsurance deductible does not apply | \$30/visit then 35% coinsurance deductible does not apply | -----none----- |
| | Preventive care / screening / immunization | No charge | No charge | 35% 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) | Lab – Office No charge X-Ray – Office \$25/visit then 10% coinsurance | Lab – Office No charge X-Ray – Office \$25/visit then 30% coinsurance | Lab – Office \$20/visit then 35% coinsurance deductible does not apply | Costs may vary by site of service. |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012022L00548>.

| | | | | | |
|--|--|---|---|--|------------------------------------|
| | | deductible does not apply | deductible does not apply | X-Ray – Office \$25/visit then 35% coinsurance deductible does not apply | |
| | Imaging (CT/PET scans, MRIs) | \$25/visit then 10% coinsurance deductible does not apply | \$25/visit then 30% coinsurance deductible does not apply | \$25/visit then 35% coinsurance deductible does not apply | Costs may vary by site of service. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ Traditional Open Drug List | Tier 1 - Typically Generic | \$15/prescription, deductible does not apply (retail) and \$30/prescription, deductible does not apply (home delivery) | \$15/prescription, deductible does not apply (retail) and \$30/prescription, deductible does not apply (home delivery) | 25% coinsurance deductible does not apply (retail) and 25% coinsurance deductible does not apply (home delivery) | *See Prescription Drug section |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | \$30/prescription, deductible does not apply (retail) and \$60/prescription, deductible does not apply (home delivery) | \$30/prescription, deductible does not apply (retail) and \$60/prescription, deductible does not apply (home delivery) | 25% coinsurance deductible does not apply (retail) and 25% coinsurance deductible does not apply (home delivery) | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | \$50/prescription, deductible does not apply (retail) and \$100/prescription, deductible does not apply (home delivery) | \$50/prescription, deductible does not apply (retail) and \$100/prescription, deductible does not apply (home delivery) | 25% coinsurance deductible does not apply (retail) and 25% coinsurance deductible does not apply (home delivery) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | 35% coinsurance | -----none----- |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | 35% coinsurance | -----none----- |
| | Emergency room care | \$150/visit then 30% coinsurance | \$150/visit then 30% coinsurance | \$150/visit then 30% coinsurance | Copay waived if admitted. |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012022L00548>.

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|---|--|--|--|--|---|
| If you need immediate medical attention | | deductible does not apply | deductible does not apply | deductible does not apply | |
| | Emergency medical transportation | Not covered | 30% coinsurance | 30% coinsurance | Non-emergency non- network Ambulance Services are limited to \$50,000 per occurrence. |
| | Urgent care | \$50/visit then 10% coinsurance deductible does not apply | \$50/visit then 30% coinsurance deductible does not apply | \$50/visit then 35% coinsurance deductible does not apply | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 35% coinsurance | 60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | 35% coinsurance | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit \$30/visit then 10% coinsurance deductible does not apply Other Outpatient 10% coinsurance deductible does not apply | Office Visit \$30/visit then 30% coinsurance deductible does not apply Other Outpatient 30% coinsurance deductible does not apply | Office Visit 35% coinsurance deductible does not apply Other Outpatient 35% coinsurance deductible does not apply | Office Visit -----none----- Other Outpatient -----none----- |
| | Inpatient services | 10% coinsurance | 30% coinsurance | 35% coinsurance | -----none----- |
| If you are pregnant | Office visits | \$30/pregnancy then 10% coinsurance deductible does not apply | \$30/pregnancy then 30% coinsurance deductible does not apply | \$30/pregnancy then 35% coinsurance deductible does not apply | One copayment per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | 35% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | 35% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | 35% coinsurance | 120 visits/benefit period for In- Network and Non- Network Providers combined. |
| | Rehabilitation services | \$20/visit deductible does not apply | 30% coinsurance | 35% coinsurance | *See Therapy Services section. |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012022L00548>.

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|---|---|---|---|---|--|
| | Habilitation services | \$20/visit deductible does not apply | 30% coinsurance | 35% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | 35% coinsurance | 60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | 35% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | Not covered | 30% coinsurance deductible does not apply | 35% coinsurance deductible does not apply | -----none----- |
| If your child needs dental or eye care | Children's eye exam | Not Applicable | No charge | Reimbursed Up to \$30 | *See Vision Services section |
| | Children's glasses | Not Applicable | No charge | Reimbursed Up to \$45 | |
| | Children's dental check-up | Not Applicable | No charge | No charge | *See Dental Services section |

Excluded Services & Other Covered Services:

| | | |
|---|--|---|
| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
| <ul style="list-style-type: none"> • Bariatric surgery • Hearing aids • Routine foot care | <ul style="list-style-type: none"> • Cosmetic surgery • Long-term care • Weight loss programs | <ul style="list-style-type: none"> • Dental care (Adult) • Routine eye care (Adult) |

| | | |
|---|---|--|
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> • Private-duty nursing in a Home Setting only | <ul style="list-style-type: none"> • Spinal Manipulation 12 visits/benefit periods | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, 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 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:

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012022L00548>.

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056

Does this plan provide Minimum Essential Coverage? Yes/No

[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/No

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/SH08012022L00548>.

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 plan's overall deductible | \$700 | ■ The plan's overall deductible | \$700 | ■ The plan's overall deductible | \$700 |
| ■ Specialist coinsurance | 30% | ■ Specialist coinsurance | 30% | ■ Specialist coinsurance | 30% |
| ■ Hospital (facility) coinsurance | 30% | ■ Hospital (facility) coinsurance | 30% | ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 0% | ■ Other coinsurance | 0% | ■ Other coinsurance | 0% |
| <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | | <p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| 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: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$200 | Deductibles | \$0 | Deductibles | \$200 |
| Copayments | \$90 | Copayments | \$1,300 | Copayments | \$300 |
| Coinsurance | \$2,500 | Coinsurance | \$0 | Coinsurance | \$500 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,850 | The total Joe would pay is | \$1,320 | The total Mia would pay is | \$1,000 |

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 844-412-0752

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 844-412-0752 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 844-412-0752.

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՝ 844-412-0752:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè n̄ià k̄e dyí ní, ɔ̀ m̄ò n̄i dyí-b̄èdjèin-djè b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ǎ́ kpǎ́ djé m̄ b̄ídjí-wùdùún b̄ó pídyi. B̄é m̄ k̄é wuɖu-zìin-nyò djò gbo wùdù k̄e, djá 844-412-0752.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য 844-412-0752 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု 844-412-0752 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844-412-0752。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl 844-412-0752.

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 844-412-0752.

Farsi (فارسی): 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 844-412-0752 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 844-412-0752.

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 844-412-0752.

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 844-412-0752.

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 844-412-0752.

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 844-412-0752.

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 844-412-0752 ।

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 844-412-0752.

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 844-412-0752.

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 844-412-0752.

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 844-412-0752.

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 844-412-0752

Language Access Services:

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 844-412-0752 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ 844-412-0752 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura 844-412-0752.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 844-412-0752 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກວ່າມແບພາສາ, ໃຫ້ໂທຫາ 844-412-0752.

Navajo (Diné): Dít naaltsoos biká'ígíí lahgo bina'idíłkídgó ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó.
Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj̄' hodiilnih 844-412-0752.

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 844-412-0752

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 844-412-0752 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 844-412-0752 aa.

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 844-412-0752.

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 844-412-0752.

Language Access Services:

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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 844-412-0752 ਤੇ ਕਾਲ ਕਰੋ।

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 844-412-0752.

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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 auoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili 844-412-0752.

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 844-412-0752.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 844-412-0752.

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 844-412-0752.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 844-412-0752 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 844-412-0752.

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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 844-412-0752.

(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 844-412-0752.

Language Access Services:

Yoruba (Yorùbá): Tí o bá ní èyíkéyǐ ìbèrè nípa àkọsílẹ̀ yí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lófẹ́ẹ̀. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe 844-412-0752.

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