

## EPC- Southwestern Ohio Educational Purchasing Council: Antwerp PPO



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/aso>. 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) 255-9952 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$500/person or \$1,000/family for In- <a href="#">Network Providers</a> .<br>\$1,000/person or \$2,000/family for Non- <a href="#">Network Providers</a> .                                                                                                                                       | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . Deductible resets January 1.                                                                                                         |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care <a href="#">Specialist</a> Visit <a href="#">Preventive Care</a> Vision for In- <a href="#">Network Providers</a> .                                                                                                                                                             | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                               | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$2,500/person or \$5,000/family for In- <a href="#">Network Providers</a> .<br>\$5,000/person or \$10,000/family for Non- <a href="#">Network Providers</a> .<br>Prescription drugs have a separate limit of <b>\$4,100</b> single / <b>\$8,200</b> family In-network & out-of-network combined. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                       |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and Non-                                                                                    | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                                                                    |                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                    | <a href="#">Network</a> Transplants.                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>            | Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 255-9952 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | No.                                                                                                                                                 | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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

| Common Medical Event                                                                                                                                                                                    | Services You May Need                                                     | What You Will Pay                                                                                    |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                         |                                                                           | In-Network Provider<br>(You will pay the least)                                                      | Non-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                           | Primary care visit to treat an injury or illness                          | \$20/visit <a href="#">deductible</a> does not apply                                                 | 40% <a href="#">coinsurance</a>                 | -----none-----                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                         | <a href="#">Specialist</a> visit                                          | \$20/visit <a href="#">deductible</a> does not apply                                                 | 40% <a href="#">coinsurance</a>                 | -----none-----                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                         | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization | No charge                                                                                            | Not covered                                     | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                         |
| <b>If you have a test</b>                                                                                                                                                                               | <a href="#">Diagnostic test</a> (x-ray, blood work)                       | 20% <a href="#">coinsurance</a>                                                                      | 40% <a href="#">coinsurance</a>                 | Costs may vary by site of service.                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                         | Imaging (CT/PET scans, MRIs)                                              | 20% <a href="#">coinsurance</a>                                                                      | 40% <a href="#">coinsurance</a>                 | Costs may vary by site of service.                                                                                                                                                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Tier 1 - Typically Generic                                                | Retail: \$15 copay<br>Mail-Order: \$30 copay                                                         | Not Covered                                     | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply<br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non- |
|                                                                                                                                                                                                         | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs          | Retail: \$40 copay<br>Mail-Order: \$80 copay                                                         | Not Covered                                     |                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                         | Tier 3 - Typically Non-Preferred Brand and Generic drugs                  | Retail: \$80 copay<br>Mail-Order: \$160 copay                                                        | Not Covered                                     |                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                         | Tier 4 - Typically Preferred Specialty (brand and generic)                | Retail: 30% coinsurance, deductible does not apply OR \$0 with Prudent RX<br>Mail-Order: Not Covered | Not Covered                                     |                                                                                                                                                                                                                                                                                                                                                   |

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

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                     |                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)       | Non-Network Provider<br>(You will pay the most)     |                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           |                                                  |                                                       |                                                     | network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | -----none-----                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | -----none-----                                                                                                                                                                                                                                                                                                                                               |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150/visit <a href="#">deductible</a> does not apply | Covered as In- <a href="#">Network</a>              | Copay waived if admitted.                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                             | Covered as In- <a href="#">Network</a>              | Non-emergency non- <a href="#">network</a> Ambulance Services are limited to \$50,000 per trip.                                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Urgent care</a>                      | \$75/visit <a href="#">deductible</a> does not apply  | 40% <a href="#">coinsurance</a>                     | -----none-----                                                                                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | 60 days/benefit period for Inpatient rehabilitation.                                                                                                                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | -----none-----                                                                                                                                                                                                                                                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>\$20 <a href="#">copay</a>            | Office Visit<br>40% <a href="#">coinsurance</a>     | Office Visit<br>-----none-----                                                                                                                                                                                                                                                                                                                               |
|                                                                           |                                                  | Other Outpatient<br>20% <a href="#">coinsurance</a>   | Other Outpatient<br>40% <a href="#">coinsurance</a> | Other Outpatient<br>-----none-----                                                                                                                                                                                                                                                                                                                           |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | -----none-----                                                                                                                                                                                                                                                                                                                                               |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).                                                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     |                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     |                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>                       | 40% <a href="#">coinsurance</a>                     | 100 visits/benefit period.                                                                                                                                                                                                                                                                                                                                   |

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

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                    |                                                 | Limitations, Exceptions, & Other Important Information               |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)      | Non-Network Provider<br>(You will pay the most) |                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Rehabilitation services</a>   | \$20/visit <a href="#">deductible</a> does not apply | 40% <a href="#">coinsurance</a>                 | Costs may vary by site of service.<br>*See Therapy Services section. |
|                                                                | <a href="#">Habilitation services</a>     | \$20/visit <a href="#">deductible</a> does not apply | 40% <a href="#">coinsurance</a>                 |                                                                      |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                      | 40% <a href="#">coinsurance</a>                 | 90 days/benefit period for skilled nursing services.                 |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                      | 40% <a href="#">coinsurance</a>                 | *See <a href="#">Durable Medical Equipment</a> Section               |
|                                                                | <a href="#">Hospice services</a>          | No charge                                            | No charge                                       | -----none-----                                                       |
| If your child needs dental or eye care                         | Children's eye exam                       | \$20/visit <a href="#">deductible</a> does not apply | 40% <a href="#">coinsurance</a>                 | *See Vision Services section                                         |
|                                                                | Children's glasses                        | Not covered                                          | Not covered                                     |                                                                      |
|                                                                | Children's dental check-up                | Not covered                                          | Not covered                                     | -----none-----                                                       |

#### Excluded Services & Other Covered Services:

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

- |                       |                           |                    |
|-----------------------|---------------------------|--------------------|
| • Acupuncture         | • Bariatric surgery       | • Cosmetic surgery |
| • Dental care (Adult) | • Dental care (Pediatric) | • Dental Check-up  |
| • Glasses for a child | • Infertility treatment   | • Long-term care   |
| • Routine foot care   | • Weight loss programs    |                    |

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

- |                                                                       |                                                                          |                                                                                                                            |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| • Chiropractic care 12 visits/benefit period                          | • Hearing aids 1 item/ear every 3 years, \$2,500 maximum/benefit period. | • Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> |
| • Private-duty nursing 82 visits/benefit period Facility Setting only | • Routine eye care (Adult)                                               |                                                                                                                            |

**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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](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](#)

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

documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

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

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

**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/aso>.

## About these Coverage Examples:



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

### Peg is Having a Baby

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,560</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$80           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,500</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

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:

| <a href="#">Cost Sharing</a>      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$400        |
| <a href="#">Copayments</a>        | \$300        |
| <a href="#">Coinsurance</a>       | \$00         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$700</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 255-9952

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 255-9952 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) 255-9952.

**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) 255-9952:

**Bassa (Bàsɔ̀ Wùdù):** M̈ dyi dyi-diè-djè b̈é b̈édjé b̈á céè-djè nià k̈e dyí ní, ɔ m̈ò nì dyí-b̈édjèin-djè b̈é m̈ k̈é gbo-kpá-kpá k̈é b̈ɔ̈ kp̈ɔ̈ djé m̈ bídjí-wùdùùn b̈ó pídyi. B̈é m̈ k̈é wuɖu-zìin-nyò d̈ò gbo wùdù k̈e, d̈á (855) 255-9952.

**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) 255-9952 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 255-9952 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) 255-9952。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāauē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin c̄ol (855) 255-9952.

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## Language Access Services:

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