

# Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. BCBSHP

## City of Marietta Blue Open Access POS OAP5 750/6.6K

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual + Family | Plan Type: POS



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.bcbsga.com/eocdps/fi> or by calling (855) 397-9267.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>\$750</b> individual / <b>\$2,250</b> family for In-Network Providers. Does not apply to Hospice, Primary Care visit, Preventive care, and Specialist visit.	You must pay all costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes; <b>\$6,600</b> individual / <b>\$13,200</b> family for In-Network Providers.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Prescription Drugs, Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes, Blue Open Access POS. For a list of In-Network providers, see <a href="http://www.bcbsga.com">www.bcbsga.com</a> or call (855) 397-9267.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this

**Questions:** Call (855) 397-9267 or visit us at [www.bcbsga.com](http://www.bcbsga.com)

GA/L/F/CITY OF MARIETTA-BLUE OPEN AC SOAP5 750/6.6K/NA/NA/01-17

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call (855) 397-9267 to request a copy.

Important Questions	Answers	Why this Matters:
		plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No; you do not need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b><u>excluded services</u></b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider’s office or clinic</b>	Primary care visit to treat an injury or illness	\$35 copay per visit	Not covered	-----none-----
	Specialist visit	\$40 copay per visit	Not covered	-----none-----
	Other practitioner office visit	Manipulative Therapy 20% coinsurance Acupuncture Not covered	Manipulative Therapy Not covered Acupuncture Not covered	Manipulative Therapy Coverage for In-Network Providers is limited to 20 visits per benefit period. Acupuncture -----none-----
	Preventive care/screening/immunization	No cost share	Not covered	-----none-----
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Lab – Office \$35 copay per visit X-Ray – Office \$35 copay per visit	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office Costs may vary by site of service. X-Ray – Office Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	-----none-----
<b>If you need drugs to treat your illness or condition</b>	Tier 1 - Generic	\$10 copay		Drugs being utilized to treat non-FDA approved indications. Smoking Cessation Products. Drugs or supplies considered experimental or investigational. Drugs newly approved by the Food and Drug Administration (FDA) are not covered until sufficient time has elapsed “post-approval” to determine and insure patient safety
	Tier 2 – Preferred Brand	\$40 copay		

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
<b>Note:</b> More information regarding your <b>prescription drug coverage</b> , please visit <a href="http://www.shawhankinsbenefits.net/cityofmarietta/">www.shawhankinsbenefits.net/cityofmarietta/</a> or contact PharmAvail at 800-933-3734.	Tier 3 – Non-Preferred Brand	\$65 copay		through actual clinical practice. Exceptions are made to these coverage exclusions for any new drug product or medication that has been determined by the FDA to be a significant therapeutic advance over similar drugs within the same therapeutic treatment class. Clinically unnecessary, brand-name (so-called “Me-Too”) medications where therapeutic or compounded alternatives are readily available (i.e., Solodyn, Vimovo, Epiduo Oracea, Doryx, Androgel, Testim, Fortesta, Axiron, Androderm, Striant, Azasite, Finacea, Amrix). HP Acthar Gel will not be covered.
	Tier 4 – Specialty Drugs (30-day’s supply limit)	20% of total allowable cost (up to a maximum of \$400/RX)		
	Tier 5 – Non-Preferred Specialty Drugs (30-day’s supply limit)	10% of total allowable cost		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	-----none-----
	Physician/surgeon fees	20% coinsurance	Not covered	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay per visit and then 0% coinsurance	Not covered	If admitted to the hospital, ER copay is waived.
	Emergency medical transportation	0% coinsurance	Not covered	-----none-----
	Urgent care	\$75 copay per visit	Not covered	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	-----none-----
	Physician/surgeon fee	20% coinsurance	Not covered	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$40 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit - Facility Charges Not covered	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Facility Visit - Facility Charges -----none-----
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	-----none-----
	Substance use disorder outpatient	Substance Use Office	Substance Use Office	Substance Use Office Visit

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	services	Visit \$40 copay per visit Substance Use Facility Visit - Facility Charges 20% coinsurance	Visit Not covered Substance Use Facility Visit - Facility Charges Not covered	-----none----- Substance Use Facility Visit - Facility Charges -----none-----
	Substance use disorder inpatient services	20% coinsurance	Not covered	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	\$45 copay per visit	Not covered	-----none-----
	Delivery and all inpatient services	20% coinsurance	Not covered	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	Not covered	Coverage for In-Network Providers is limited to 120 visits per benefit period.
	Rehabilitation services	20% coinsurance	Not covered	Coverage for In-Network Providers is limited to 20 visits per benefit period for Physical and Occupational Therapy combined. Coverage for In-Network Providers is limited to 20 visits per benefit period for Speech Therapy.
	Habilitation services	20% coinsurance	Not covered	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	20% coinsurance	Not covered	Coverage for In-Network Providers is limited to 60 days limit per benefit period.
	Durable medical equipment	20% coinsurance	Not covered	-----none-----
	Hospice service	No cost share	Not covered	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	-----none-----
	Glasses	Not covered	Not covered	-----none-----
	Dental check-up	Not covered	Not covered	-----none-----

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Non-emergency care outside US
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 397-9267. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals P.O. Box 105449 Atlanta, GA 30548-5449	Department of Labor, Employee Benefits Security Administration (866) 444-EBSA (3272) <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>	Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 <a href="http://www.oci.ga.gov/ConsumerService/Home.aspx">http://www.oci.ga.gov/ConsumerService/Home.aspx</a>
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## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

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

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## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,340
- Patient pays \$2,200

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$750
Copays	\$350
Coinsurance	\$930
Limits or exclusions	\$170
<b>Total</b>	<b>\$2,200</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,260
- Patient pays \$4,140

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$750
Copays	\$250
Coinsurance	\$210
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$4,140</b>

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call (855) 397-9267 or visit us at [www.bcbgsa.com](http://www.bcbgsa.com)

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## 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) 397-9267

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 397-9267 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) 397-9267

**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) 397-9267:

**Bassa (Básó Wùdù):** M̄ dyi dyi-diè-dè b̄é b̄édé b̄á céè-dè n̄ià ke dyí ní, ɔ mò n̄i dyí-b̄èd̄èin-d̄è b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kpǎ d̄é m̄ bídí-wùdùun b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù ke, d̄á (855) 397-9267.

**Bengali (বাংলা):** যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (855) 397-9267

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 397-9267 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) 397-9267。

**Dinka (Dinka):** Na n̄ɔŋ thiëc n̄e ke de yā thorë, ke yin n̄ɔŋ loŋ b̄e yi kuony ku w̄er alëu b̄e ḡeer yic yin ne thoŋ du ke cin w̄eu t̄äüë ke piny. Te k̄or yin ba jam w̄enë ran ye thok geryic, ke yin c̄ol (855) 397-9267.

**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 (855) 397-9267.

**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 (855) 397-9267 تماس بگیرید.

**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 (855) 397-9267.

## Language Access Services:

**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 (855) 397-9267.

**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 (855) 397-9267.

**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 (855) 397-9267.

**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 (855) 397-9267.

**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 (855) 397-9267 ।

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## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (855) 397-9267 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (855) 397-9267.

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 397-9267.

**Navajo (Diné):** Dii naaltsoos biká'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 (855) 397-9267.

**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 (855) 397-9267

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 397-9267 bilbilla.

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**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, (855) 397-9267 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 (855) 397-9267.

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**(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 (855) 397-9267.

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