## The University of Akron: Active Gold PPO Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage Period: 01/01/2020 – 12/31/2020**

**Coverage for:** Individual + Family | **Plan Type:** PPO



**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.anthem.com/eocdps/aso>or by calling (844) 653-7397.

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| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | **$400** individual / **$800** family for In-Network Providers. Does not apply to Emergency Room Services, Primary Care visit, Preventive care, and Specialist visit. **$800** individual / **$1,600** family for Out-of-Network Providers. Does not apply to Emergency Room Services. In- Network Providers and Non- Network Providers deductibles are combined. Satisfying one helps satisfy the other. | You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers. |
| **Is there an out–of– pocket limit on my expenses?** | Yes; **$2,500** individual / **$5,000** family for In-Network Providers. **$5,000** individual /  **$10,000** family for Out-of- Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are combined. Satisfying one helps satisfy the other. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This maximum also includes co-pays and coinsurances from prescriptions. This limit helps you plan for health care expenses. |

**Questions:** Call (844) 653-7397 or visit us at [www.anthem.com](http://www.anthem.com/) OH/L/A/THEUNIVRSTYOFAKRONACTGOLDPLAN-PPO/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 (844) 653-7397 to request a copy.

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| **Important Questions** | **Answers** | **Why this Matters:** |
| **What is not included in the out–of–pocket limit?** | Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, Non-Network Transplant Services, Premiums, Balance- Billed charges, and Health Care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the **out–of–pocket limit**. |
| **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 *specific*  covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, Blue Card PPO.  For a list of In-Network providers, see [www.anthem.com](http://www.anthem.com/) or call **(844) 653-7397**. | If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No; you do not need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn’t cover?** | Yes. | Some of the services this plan doesn’t cover are listed on page 7. See your policy or plan document for additional information about **excluded services.** |



* **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.

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| **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** |
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | $25 copay per visit | 35% coinsurance | --------none-------- |
| Specialist visit | $35 copay per visit | 35% coinsurance | --------none-------- |
| Other practitioner office visit | Manipulative Therapy 15% coinsurance Acupuncture  15% coinsurance | Manipulative Therapy 35% coinsurance Acupuncture  35% coinsurance | Manipulative Therapy  Coverage for In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period including Acupuncture, Physical, Occupational and Speech Therapy includes manipulations only regardless of provider specialty. Costs may vary by site of service.  Acupuncture  Coverage for In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period including Chiropractic, Physical, Occupational and Speech Therapy. |
| Preventive care/screening/immunization | No cost share | 35% coinsurance | Hearing exam (routine): Not covered. |

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| **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** |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab – Office 15% coinsurance X-Ray – Office 15% coinsurance | Lab – Office 35% coinsurance X-Ray – Office 35% coinsurance | Lab – Office  Pre-certification may be required. X-Ray – Office  Pre-certification may be required. |
| Imaging (CT/PET scans, MRIs) | 15% coinsurance | 35% coinsurance | Pre-certification may be required. |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.caremark.com.](http://www.caremark.com/) | Tier 1 - Typically Generic | $10 retail co-pay  $25 mail order co-pay | $10 retail co-pay  $25 mail order co-pay | Retail maximum 30 day supply. Mail order maximum 90 day supply.  Several drugs require prior authorization, step therapy, quantity and/or age limits. Refer to plan document for details |
| Tier 2 - Typically Preferred / Brand | 25% coinsurance | 25% coinsurance | $70 retail maximum for 30 day supply. $175 mail order maximum for 90 day supply. Several drugs require prior authorization, step therapy, quantity and/or age limits. Refer to plan document for details. |
| Tier 3 - Typically Non-Preferred / Specialty Drugs | 35% coinsurance | 35% coinsurance | $85 retail maximum for 30 day supply. $175 mail order maximum for 90 day supply. Several drugs require prior authorization, step therapy, quantity and/or age limits. Refer to plan document for details. |
| Tier 4 - Typically Specialty Drugs | 30% coinsurance | n/a | $125 maximum. Several drugs require prior authorization, step therapy, quantity and/or age limits. Refer to plan document for details. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 35% coinsurance | --------none-------- |
| Physician/surgeon fees | 15% coinsurance | 35% coinsurance | --------none-------- |
|  | Emergency room services | $100 copay per visit | Covered as In-Network | Copay waived if admitted.  Pre-certification may be required. |

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| **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** |
| **If you need immediate medical attention** | Emergency medical transportation | 15% coinsurance | Covered as In-Network | --------none-------- |
| Urgent care | $50 copay per visit | 35% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 35% coinsurance | --------none-------- |
| Physician/surgeon fee | 15% coinsurance | 35% coinsurance | --------none-------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit  $25 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges  $25 copay per visit | Mental/Behavioral Health Office Visit 35% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges  35% coinsurance | Mental/Behavioral Health Office Visit  --------none--------  Mental/Behavioral  Health Facility Visit - Facility Charges  --------none-------- |
| Mental/Behavioral health inpatient services | 15% coinsurance | 35% coinsurance | --------none-------- |
| Substance use disorder outpatient services | Substance Use Office Visit  $25 copay per visit Substance Use Facility Visit - Facility Charges  $25 copay per visit | Substance Use Office Visit  35% coinsurance Substance Use Facility Visit - Facility Charges 35% coinsurance | Substance Use Office Visit  --------none--------  Substance Use Facility Visit - Facility Charges  --------none-------- |
| Substance use disorder inpatient services | 15% coinsurance | 35% coinsurance | --------none-------- |
| **If you are pregnant** | Prenatal and postnatal care | $25 copay per visit | 35% coinsurance | Copay applies for 1st prenatal visit. There may be other levels of cost share that are contingent on how services are provided. |
| Delivery and all inpatient services | 15% coinsurance | 35% coinsurance | Pre-certification may be required. |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 35% coinsurance | Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period including private duty nursing. |

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| **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** |
|  | Rehabilitation services | 15% coinsurance | 35% coinsurance | Coverage for In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period for Physical, Occupational, Speech Therapy including Acupuncture and Chiropractic services. Costs may vary by site of service. |
| Habilitation services | 15% Coinsurance;  $25 Copay/visit for mental/ behavioral health | 35% Coinsurance | Limited to 20 visits each for speech and occupational therapy; 30 visits per year for mental/behavioral health and 20 hours per week for clinical therapeutic intervention. |
| Skilled nursing care | 15% coinsurance | 35% coinsurance | Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 days limit per benefit period. |
| Durable medical equipment | 15% coinsurance | 35% coinsurance | Pre-certification may be required. |
| Hospice service | 15% coinsurance | 35% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Eye exam | No charge | 35% coinsurance | Limited to one exam every two years. |
| 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.)**

* Cosmetic surgery  Routine foot care unless you have been
* Dental care (adult) diagnosed with diabetes.
* Hearing aids  Weight loss programs
* Infertility treatment
* Long- term care

**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.)**

* Acupuncture  Routine eye care (adult)
* Bariatric surgery
* Chiropractic care
* Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide)
* Private-duty nursing only covered in the home. Coverage is limited to 120 visits per benefit period including home health 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 (844) 653-7397. You may also contact your state insurance department, the

* 1. 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: Grievance and Appeals

P.O. Box 105568 Atlanta, GA 30348-5568

### 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 adoołwoł íínízinigo t’áá diné k’éjíígo, t’áá shoodí ba na’ałníhí ya sidáhí bich’į naabídííłkiid. Eí doo biigha daago ni ba’nija’go ho’aałagíí bich’į hodiilní. Hai’dąą iini’taago eíya, t’áá shoodí diné ya atáh halne’ígíí ní béésh bee hane’í wólta’ bi’ki si’niilígíí bi’kéhgo bich’į 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.

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

# About These Coverage Examples:

**Having a baby**

(normal delivery)

**Managing type 2 diabetes**

(routine maintenance of

a well-controlled condition)

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.

#### Amount owed to providers: $7,540

* + - **Plan pays** $6,185
    - **Patient pays** $1,355

#### Sample care costs:

* + - * **Amount owed to providers:** $5,400
      * **Plan pays** $1,660
      * **Patient pays** $3,740

#### 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 |
| **Total** | **$5,400** |

**Patient pays:**



**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.

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|  | 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 |  |
|  | **Total** | **$7,540** |  |

**Patient pays:**

|  |  |
| --- | --- |
| Deductibles | $400 |
| Copays | $250 |
| Coinsurance | $160 |
| Limits or exclusions | $2,930 |
| **Total** | $3,740 |

|  |  |
| --- | --- |
| Deductibles | $400 |
| Copays | $25 |
| Coinsurance | $760 |
| Limits or exclusions | $170 |
| **Total** | $1,355 |

**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**, **co**

**payments**, 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 (844) 653-7397 or visit us at [www.anthem.com](http://www.anthem.com/) OH/L/A/THEUNIVRSTYOFAKRONACTGOLDPLAN-PPO/NA/NA/01-17

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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 (844) 653-7397

**Amharic (**አማርኛ**)**፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 653-7397 ይደውሉ።

.(844) 653-7397image5

**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) 653-7397:



(844) 653-7397.



(844) 653-7397



(844) 653-7397

**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) 653-7397。



(844) 653-7397.

**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) 653-7397.



(844) 653-7397

**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) 653-7397.

**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 (844) 653-7397.

**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) 653-7397.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ ��નો હોય તો, કોઈપણ ખચર્ વગર આપની ભાષામાં મદદ અને માિહતી મેળવવાનો તમને અિધકાર છે. દુભાિષયા સાથે વાત કરવા માટે, કોલ કરો (844) 653-7397.

**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) 653-7397.



(844) 653-7397

**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) 653-7397.

**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) 653-7397.

**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) 653-7397.

**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) 653-7397.

**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) 653-7397



(844) 653-7397

**Language Access Services:**



(844) 653-7397

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 653-7397.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 653-7397 로 문의하십시오.



(844) 653-7397.



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