



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/as0>. 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 (833) 807-1875 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$400/single or \$1,200/family for In- <u>Network Providers</u> . \$2,000/single or \$6,000/family for Out-of- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Primary Care. <u>Specialist</u> Visit. <u>Preventive Care</u> . For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$1,500/single or \$4,500/family for In- <u>Network Providers</u> . \$5,000/single or \$15,000/family for Out-of- <u>Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. Blue Card PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (833) 807-1875 for a list of <u>network providers</u> . Costs may vary by site of service and how the provider bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	\$40/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	30% <a href="#">coinsurance</a>	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$10/prescription (retail) and \$20/prescription (home delivery)	Not covered (retail and home delivery)	Most home delivery is 90-day supply. For more information, refer to "National Drug List" at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a> *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$20/prescription (retail) and \$40/prescription (home delivery)	Not covered (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$35/prescription (retail) and \$70/prescription (home delivery)	Not covered (retail and home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	\$35/prescription (retail) and \$70/prescription (home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	\$50/visit then 30% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	Covered as In-Network	10% <a href="#">coinsurance</a> for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	No charge for ground ambulance. 10% coinsurance for air ambulance.	\$2,000 maximum/transport for ground ambulance and \$20,000

\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<u><a href="#">Urgent care</a></u>				for air ambulance for Out-of-Network Providers.
	<u><a href="#">Urgent care</a></u>	10% <u><a href="#">coinsurance</a></u>	Covered as In-Network	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	-----none-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit \$20/visit <u><a href="#">deductible</a></u> does not apply Other Outpatient 10% <u><a href="#">coinsurance</a></u>	Office Visit 10% <u><a href="#">coinsurance</a></u> Other Outpatient 10% <u><a href="#">coinsurance</a></u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	10% <u><a href="#">coinsurance</a></u>	\$100/admission then 10% <u><a href="#">coinsurance</a></u>	10% <u><a href="#">coinsurance</a></u> for Inpatient Physician Fee.
<b>If you are pregnant</b>	Office visits	\$20/visit for the first 1 visit <u><a href="#">deductible</a></u> does not apply	30% <u><a href="#">coinsurance</a></u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	
	Childbirth/delivery facility services	10% <u><a href="#">coinsurance</a></u>	\$100/admission then 30% <u><a href="#">coinsurance</a></u>	
<b>If you need help recovering or have other special health needs</b>	<u><a href="#">Home health care</a></u>	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	120 visits/benefit period.
	<u><a href="#">Rehabilitation services</a></u>	\$40/visit <u><a href="#">deductible</a></u> does not apply	30% <u><a href="#">coinsurance</a></u>	60 visit limit/benefit period, combined for therapy services.
	<u><a href="#">Habilitation services</a></u>	\$40/visit <u><a href="#">deductible</a></u> does not apply	30% <u><a href="#">coinsurance</a></u>	*See Therapy Services section.
	<u><a href="#">Skilled nursing care</a></u>	10% <u><a href="#">coinsurance</a></u>	\$100/admission then 30% <u><a href="#">coinsurance</a></u>	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u><a href="#">Durable medical equipment</a></u>	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	*See <u><a href="#">Durable Medical Equipment</a></u> Section
	<u><a href="#">Hospice services</a></u>	10% <u><a href="#">coinsurance</a></u>	30% <u><a href="#">coinsurance</a></u>	12 months or less to live.
	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	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.)

- Cosmetic surgery
- Eye exams for a child
- Routine eye care (Adult)
- Dental care (Adult)
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes
- Dental Check-up
- Long-term care
- Weight loss programs

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

- Acupuncture 30 visits/benefit period
- Hearing aids \$4,000 maximum/24 months.
- Private-duty nursing only covered in the Home. 120 visits/benefit period.
- Bariatric surgery for In-Network Providers
- Infertility treatment \$30,000 maximum/lifetime
- Chiropractic care 30 days/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhc.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.healthcaremarketplace.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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 documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievance and Appeals, P. O. Box 54159, Los Angeles, CA 90054-0519

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhc.ca.gov/>

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

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\* For more information about limitations and exceptions, see [plan](#) or policy document at <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 [plan's](#) overall [deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#)
- [Specialist copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

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:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,200

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</b>

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:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$10

#### *What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,430</b>

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:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200

#### *What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</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 1-888-254-2721

**Amharic (አማርኛ):** አለሁ ሌሎች ማንኛውም ብቻ ከለዋቸው በፈለጊ ቅጽ እና የሆነ መረጃ በለዚ የማንኛውም መሰት አለዋቸው:: አስተርጓሚ ለማንኛው 1-888-254-2721 ይደማል::

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-888-254-2721.

**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՝ 1-888-254-2721:

**Bassa (Basa Wùqdù):** M dyi dyi-diè-dé bá bédé bá céè-dé nià ke dyí ní, o mò nì dyí-bédéin-dé bá m ká gbo-kpá-kpá ká bá kpá dé m bídí-wùqdùún bá pídyi. Bé m ká wuqu-zìin-nyò dò gbo wùqdù ke, qá 1-888-254-2721.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য 1-888-254-2721 -তে কল করুন।

**Burmese (မြန်မာ):** ဤတရုပ်တတ်နှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြန်ရန် ဖြစ် 1-888-254-2721 ခို့ 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 1-888-254-2721。

**Dinka (Dinka):** Na nɔj thiēec nē ke de yā thorē, ke yin nɔj loj bē yi kuony ku wər alēu bē gəer yic yin ne thoj du ke cin wēu tāāuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin col 1-888-254-2721.

**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 1-888-254-2721.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 تماس بگیرید.

## Language Access Services:

**French (Français)** : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 1-888-254-2721.

**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 1-888-254-2721.

**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 1-888-254-2721.

**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 1-888-254-2721.

**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 1-888-254-2721.

**Hindi (हिंदी)**: अगर आपके पास इस दस्तावेज 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 1-888-254-2721 |

**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 1-888-254-2721.

**Igbo (Igbo)**: O bụr ụ na ị nwere ajụụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkowa okwu kwuo okwu, kpọọ 1-888-254-2721.

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## Language Access Services:

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**Lao (ພາສາລາວ):** ທ່ານມີຄໍາຖາມໃດໆກ່ອນກັບພາກສານນີ້, ທ່ານມີສິດໄດ້ກັບຄວາມຮ່ວມຫຼື້ນ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ແລ້ວ. ເພື່ອໄຫວ້ມີກັບໜ້າ 1-888-254-2721.

**Navajo (Diné):** Díí naaltsoos biká'ígíí Łahgo bina'ídílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bázhí ilníg óó. Ata' halne'ígíí Ła' bich'í' hadeesdzih nínízingo kojí' hodíílnih 1-888-254-2721.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-888-254-2721

**Oromo (Oromifaa):** Sanadi kanaa wajiiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeefanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।

## Language Access Services:

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## Language Access Services:

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