




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/ or call 1-888-642-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$100 /person or \$200 /family for in-network providers. \$200 /person or \$400 /family for out-of-network providers.	Generally you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive services, office visits, prescription drugs, out-patient surgery, hospital stays, behavioral health, and routine vision.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,000 /person or \$4,000 /family for in-network provider. \$3,000 /person or \$6,000 /family for out-of-network provider.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Dental, routine vision, 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 .
Will you pay less if you use a network provider ?	Yes. See www.anthem.com or call 1-800-552-2682 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.thelocalchoice.virginia.gov.

Important Questions	Answers	Why This Matters:
		network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	\$15/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Specialist visit	\$25/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Preventive care/screening /immunization	No charge	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at anthem.com/tlc	Tier 1 - Typically Generic drugs	\$10/ copay (retail); \$20/ copay (home delivery)	\$10/ copay (retail); \$20/ copay (home delivery)	Retail up to 34 day supply; home delivery up to 90 day supply. Mandatory generic program. If you or your doctor requests a brand named drug when a generic is available, you pay the brand copay plus the difference between the allowable charge for the generic and the brand named drug. Balance billing may occur for out-of-network services.
	Tier 2 - Typically Preferred / Brand drugs	\$30/ copay (retail); \$60/ copay (home delivery)	\$30/ copay (retail); \$60/ copay (home delivery)	
	Tier 3 - Typically Non-Preferred / Specialty drugs	\$45/ copay (retail); \$90/ copay (home delivery)	\$45/ copay (retail); \$90/ copay (home delivery)	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Typically Specialty drugs	\$55/ copay (retail); \$110/ copay (home delivery)	\$55/ copay (retail); \$110/ copay (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Physician/surgeon fees	\$15 PCP; \$25 Specialist/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If you need immediate medical attention	Emergency room care	\$100/visit	Covered as In-Network	Copay waived if admitted. Balance billing may occur for out-of-network services.
	Emergency medical transportation	20% coinsurance after deductible	Covered as In-Network	Balance billing may occur for out-of-network services.
	Urgent care	\$15 PCP; \$25 Specialist/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200/stay	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Physician/surgeon fee	No charge	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit \$15/visit Other Outpatient \$100/visit	30% coinsurance after deductible	Balance billing may occur for out-of-network services. Employee Assistance Program (EAP) covered at no charge with up to 4 visits per incident per plan year.
	Inpatient services	\$200/stay	30% coinsurance after deductible	
If you are pregnant	Office visits	\$15 PCP; \$25 Specialist/visit	30% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Balance billing may occur for out-of-network services.
	Childbirth/delivery professional services	No charge	30% coinsurance after deductible	
	Childbirth/delivery facility services	\$200/stay	30% coinsurance after deductible	
If you need help recovering or have other	Home health care	No charge	30% coinsurance after deductible	90 visits/benefit period. Balance billing may occur for out-of-network services.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
special health needs	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Skilled nursing care	No charge	30% coinsurance after deductible	180 day/benefit period. Balance billing may occur for out-of-network services.
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Hospice service	No charge	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If your child needs dental or eye care	Eye exam	\$25 copay	Balance after \$50	Limit one exam per plan year under the age of 19.
	Glasses	\$20 copay for polycarbonate standard single lenses; balance over \$100 for frames	Balance after \$50 for polycarbonate standard single lenses; balance over \$80 for frames	-----none-----
	Dental check-up	No charge	Covered as in-network	Balance billing may occur for out-of-network services.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.thelocalchoice.virginia.gov.

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
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.

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

- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbs.com.
- Chiropractic care
- Private-duty nursing
- Routine eye care
- Dental care (adult) - diagnostic and preventive only

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 or call 1-800-318-2596.

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: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.-----

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	\$100
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$270
Coinsurance	\$105
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$535

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$100
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$870
Coinsurance	\$359
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,384

Mia's Simple Fracture

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

■ The plan's overall deductible	\$100
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$200
■ Other coinsurance	10%

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	\$1,970
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$475
Coinsurance	\$183
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$758

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-642-4414.

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 1-800-552-2682

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-800-552-2682

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Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-800-552-2682.

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՝ 1-800-552-2682 :

Bassa (𞀀𞀃𞀆𞀇𞀈𞀉𞀊𞀋𞀌𞀍𞀎𞀏𞀐𞀑𞀒𞀓𞀔𞀕𞀖𞀗𞀘𞀙𞀚𞀛𞀜𞀝𞀞𞀟𞀠𞀡𞀢𞀣𞀤𞀥𞀦𞀧𞀨𞀩𞀪𞀫𞀬𞀭𞀮𞀯𞀰𞀱𞀲𞀳𞀴𞀵𞀶𞀷𞀸𞀹𞀺𞀻𞀼𞀽𞀾𞀿𞁀𞁁𞁂𞁃𞁄𞁅𞁆𞁇𞁈𞁉𞁊𞁋𞁌𞁍𞁎𞁏𞁐𞁑𞁒𞁓𞁔𞁕𞁖𞁗𞁘𞁙𞁚𞁛𞁜𞁝𞁞𞁟𞁠𞁡𞁢𞁣𞁤𞁥𞁦𞁧𞁨𞁩𞁪𞁫𞁬𞁭𞁮𞁯𞁰𞁱𞁲𞁳𞁴𞁵𞁶𞁷𞁸𞁹𞁺𞁻𞁼𞁽𞁾𞁿𞂀𞂁𞂂𞂃𞂄𞂅𞂆𞂇𞂈𞂉𞂊𞂋𞂌𞂍𞂎𞂏𞂐𞂑𞂒𞂓𞂔𞂕𞂖𞂗𞂘𞂙𞂚𞂛𞂜𞂝𞂞𞂟𞂠𞂡𞂢𞂣𞂤𞂥𞂦𞂧𞂨𞂩𞂪𞂫𞂬𞂭𞂮𞂯𞂰𞂱𞂲𞂳𞂴𞂵𞂶𞂷𞂸𞂹𞂺𞂻𞂼𞂽𞂾𞂿𞃀𞃁𞃂𞃃𞃄𞃅𞃆𞃇𞃈𞃉𞃊𞃋𞃌𞃍𞃎𞃏𞃐𞃑𞃒𞃓𞃔𞃕𞃖𞃗𞃘𞃙𞃚𞃛𞃜𞃝𞃞𞃟𞃠𞃡𞃢𞃣𞃤𞃥𞃦𞃧𞃨𞃩𞃪𞃫𞃬𞃭𞃮𞃯𞃰𞃱𞃲𞃳𞃴𞃵𞃶𞃷𞃸𞃹𞃺𞃻𞃼𞃽𞃾𞃿𞄀𞄁𞄂𞄃𞄄𞄅𞄆𞄇𞄈𞄉𞄊𞄋𞄌𞄍𞄎𞄏𞄐𞄑𞄒𞄓𞄔𞄕𞄖𞄗𞄘𞄙𞄚𞄛𞄜𞄝𞄞𞄟𞄠𞄡𞄢𞄣𞄤𞄥𞄦𞄧𞄨𞄩𞄪𞄫𞄬𞄭𞄮𞄯𞄰𞄱𞄲𞄳𞄴𞄵𞄶𞄷𞄸𞄹𞄺𞄻𞄼𞄽𞄾𞄿𞅀𞅁𞅂𞅃𞅄𞅅𞅆𞅇𞅈𞅉𞅊𞅋𞅌𞅍𞅎𞅏𞅐𞅑𞅒𞅓𞅔𞅕𞅖𞅗𞅘𞅙𞅚𞅛𞅜𞅝𞅞𞅟𞅠𞅡𞅢𞅣𞅤𞅥𞅦𞅧𞅨𞅩𞅪𞅫𞅬𞅭𞅮𞅯𞅰𞅱𞅲𞅳𞅴𞅵𞅶𞅷𞅸𞅹𞅺𞅻𞅼𞅽𞅾𞅿𞆀𞆁𞆂𞆃𞆄𞆅𞆆𞆇𞆈𞆉𞆊𞆋𞆌𞆍𞆎𞆏𞆐𞆑𞆒𞆓𞆔𞆕𞆖𞆗𞆘𞆙𞆚𞆛𞆜𞆝𞆞𞆟𞆠𞆡𞆢𞆣𞆤𞆥𞆦𞆧𞆨𞆩𞆪𞆫𞆬𞆭𞆮𞆯𞆰𞆱𞆲𞆳𞆴𞆵𞆶𞆷𞆸𞆹𞆺𞆻𞆼𞆽𞆾𞆿𞇀𞇁𞇂𞇃𞇄𞇅𞇆𞇇𞇈𞇉𞇊𞇋𞇌𞇍𞇎𞇏𞇐𞇑𞇒𞇓𞇔𞇕𞇖𞇗𞇘𞇙𞇚𞇛𞇜𞇝𞇞𞇟𞇠𞇡𞇢𞇣𞇤𞇥𞇦𞇧𞇨𞇩𞇪𞇫𞇬𞇭𞇮𞇯𞇰𞇱𞇲𞇳𞇴𞇵𞇶𞇷𞇸𞇹𞇺𞇻𞇼𞇽𞇾𞇿𞈀𞈁𞈂𞈃𞈄𞈅𞈆𞈇𞈈𞈉𞈊𞈋𞈌𞈍𞈎𞈏𞈐𞈑𞈒𞈓𞈔𞈕𞈖𞈗𞈘𞈙𞈚𞈛𞈜𞈝𞈞𞈟𞈠𞈡𞈢𞈣𞈤𞈥𞈦𞈧𞈨𞈩𞈪𞈫𞈬𞈭𞈮𞈯𞈰𞈱𞈲𞈳𞈴𞈵𞈶𞈷𞈸𞈹𞈺𞈻𞈼𞈽𞈾𞈿𞉀𞉁𞉂𞉃𞉄𞉅𞉆𞉇𞉈𞉉𞉊𞉋𞉌𞉍𞉎𞉏𞉐𞉑𞉒𞉓𞉔𞉕𞉖𞉗𞉘𞉙𞉚𞉛𞉜𞉝𞉞𞉟𞉠𞉡𞉢𞉣𞉤𞉥𞉦𞉧𞉨𞉩𞉪𞉫𞉬𞉭𞉮𞉯𞉰𞉱𞉲𞉳𞉴𞉵𞉶𞉷𞉸𞉹𞉺𞉻𞉼𞉽𞉾𞉿𞊀𞊁𞊂𞊃𞊄𞊅𞊆𞊇𞊈𞊉𞊊𞊋𞊌𞊍𞊎𞊏𞊐𞊑𞊒𞊓𞊔𞊕𞊖𞊗𞊘𞊙𞊚𞊛𞊜𞊝𞊞𞊟𞊠𞊡𞊢𞊣𞊤𞊥𞊦𞊧𞊨𞊩𞊪𞊫𞊬𞊭𞊮𞊯𞊰𞊱𞊲𞊳𞊴𞊵𞊶𞊷𞊸𞊹𞊺𞊻𞊼𞊽𞊾𞊿𞋀𞋁𞋂𞋃𞋄𞋅𞋆𞋇𞋈𞋉𞋊𞋋𞋌𞋍𞋎𞋏𞋐𞋑𞋒𞋓𞋔𞋕𞋖𞋗𞋘𞋙𞋚𞋛𞋜𞋝𞋞𞋟𞋠𞋡𞋢𞋣𞋤𞋥𞋦𞋧𞋨𞋩𞋪𞋫𞋬𞋭𞋮𞋯𞋰𞋱𞋲𞋳𞋴𞋵𞋶𞋷𞋸𞋹𞋺𞋻𞋼𞋽𞋾𞋿𞌀𞌁𞌂𞌃𞌄𞌅𞌆𞌇𞌈𞌉𞌊𞌋𞌌𞌍𞌎𞌏𞌐𞌑𞌒𞌓𞌔𞌕𞌖𞌗𞌘𞌙𞌚𞌛𞌜𞌝𞌞𞌟𞌠𞌡𞌢𞌣𞌤𞌥𞌦𞌧𞌨𞌩𞌪𞌫𞌬𞌭𞌮𞌯𞌰𞌱𞌲𞌳𞌴𞌵𞌶𞌷𞌸𞌹𞌺𞌻𞌼𞌽𞌾𞌿𞍀𞍁𞍂𞍃𞍄𞍅𞍆𞍇𞍈𞍉𞍊𞍋𞍌𞍍𞍎𞍏𞍐𞍑𞍒𞍓𞍔𞍕𞍖𞍗𞍘𞍙𞍚𞍛𞍜𞍝𞍞𞍟𞍠𞍡𞍢𞍣𞍤𞍥𞍦𞍧𞍨𞍩𞍪𞍫𞍬𞍭𞍮𞍯𞍰𞍱𞍲𞍳𞍴𞍵𞍶𞍷𞍸𞍹𞍺𞍻𞍼𞍽𞍾𞍿𞎀𞎁𞎂𞎃𞎄𞎅𞎆𞎇𞎈𞎉𞎊𞎋𞎌𞎍𞎎𞎏𞎐𞎑𞎒𞎓𞎔𞎕𞎖𞎗𞎘𞎙𞎚𞎛𞎜𞎝𞎞𞎟𞎠𞎡𞎢𞎣𞎤𞎥𞎦𞎧𞎨𞎩𞎪𞎫𞎬𞎭𞎮𞎯𞎰𞎱𞎲𞎳𞎴𞎵𞎶𞎷𞎸𞎹𞎺𞎻𞎼𞎽𞎾𞎿𞏀𞏁𞏂𞏃𞏄𞏅𞏆𞏇𞏈𞏉𞏊𞏋𞏌𞏍𞏎𞏏𞏐𞏑𞏒𞏓𞏔𞏕𞏖𞏗𞏘𞏙𞏚𞏛𞏜𞏝𞏞𞏟𞏠𞏡𞏢𞏣𞏤𞏥𞏦𞏧𞏨𞏩𞏪𞏫𞏬𞏭𞏮𞏯𞏰𞏱𞏲𞏳𞏴𞏵𞏶𞏷𞏸𞏹𞏺𞏻𞏼𞏽𞏾𞏿𞐀𞐁𞐂𞐃𞐄𞐅𞐆𞐇𞐈𞐉𞐊𞐋𞐌𞐍𞐎𞐏𞐐𞐑𞐒𞐓𞐔𞐕𞐖𞐗𞐘𞐙𞐚𞐛𞐜𞐝𞐞𞐟𞐠𞐡𞐢𞐣𞐤𞐥𞐦𞐧𞐨𞐩𞐪𞐫𞐬𞐭𞐮𞐯𞐰𞐱𞐲𞐳𞐴𞐵𞐶𞐷𞐸𞐹𞐺𞐻𞐼𞐽𞐾𞐿𞑀𞑁𞑂𞑃𞑄𞑅𞑆𞑇𞑈𞑉𞑊𞑋𞑌𞑍𞑎𞑏𞑐𞑑𞑒𞑓𞑔𞑕𞑖𞑗𞑘𞑙𞑚𞑛𞑜𞑝𞑞𞑟𞑠𞑡𞑢𞑣𞑤𞑥𞑦𞑧𞑨𞑩𞑪𞑫𞑬𞑭𞑮𞑯𞑰𞑱𞑲𞑳𞑴𞑵𞑶𞑷𞑸𞑹𞑺𞑻𞑼𞑽𞑾𞑿𞒀𞒁𞒂𞒃𞒄𞒅𞒆𞒇𞒈𞒉𞒊𞒋𞒌𞒍𞒎𞒏𞒐𞒑𞒒𞒓𞒔𞒕𞒖𞒗𞒘𞒙𞒚𞒛𞒜𞒝𞒞𞒟𞒠𞒡𞒢𞒣𞒤𞒥𞒦𞒧𞒨𞒩𞒪𞒫𞒬𞒭𞒮𞒯𞒰𞒱𞒲𞒳𞒴𞒵𞒶𞒷𞒸𞒹𞒺𞒻𞒼𞒽𞒾𞒿𞓀𞓁𞓂𞓃𞓄𞓅𞓆𞓇𞓈𞓉𞓊𞓋𞓌𞓍𞓎𞓏𞓐𞓑𞓒𞓓𞓔𞓕𞓖𞓗𞓘𞓙𞓚𞓛𞓜𞓝𞓞𞓟𞓠𞓡𞓢𞓣𞓤𞓥𞓦𞓧𞓨𞓩𞓪𞓫𞓮𞓯𞓬𞓭𞓰𞓱𞓲𞓳𞓴𞓵𞓶𞓷𞓸𞓹𞓺𞓻𞓼𞓽𞓾𞓿𞔀𞔁𞔂𞔃𞔄𞔅𞔆𞔇𞔈𞔉𞔊𞔋𞔌𞔍𞔎𞔏𞔐𞔑𞔒𞔓𞔔𞔕𞔖𞔗𞔘𞔙𞔚𞔛𞔜𞔝𞔞𞔟𞔠𞔡𞔢𞔣𞔤𞔥𞔦𞔧𞔨𞔩𞔪𞔫𞔬𞔭𞔮𞔯𞔰𞔱𞔲𞔳𞔴𞔵𞔶𞔷𞔸𞔹𞔺𞔻𞔼𞔽𞔾𞔿𞕀𞕁𞕂𞕃𞕄𞕅𞕆𞕇𞕈𞕉𞕊𞕋𞕌𞕍𞕎𞕏𞕐𞕑𞕒𞕓𞕔𞕕𞕖𞕗𞕘𞕙𞕚𞕛𞕜𞕝𞕞𞕟𞕠𞕡𞕢𞕣𞕤𞕥𞕦𞕧𞕨𞕩𞕪𞕫𞕬𞕭𞕮𞕯𞕰𞕱𞕲𞕳𞕴𞕵𞕶𞕷𞕸𞕹𞕺𞕻𞕼𞕽𞕾𞕿𞖀𞖁𞖂𞖃𞖄𞖅𞖆𞖇𞖈𞖉𞖊𞖋𞖌𞖍𞖎𞖏𞖐𞖑𞖒𞖓𞖔𞖕𞖖𞖗𞖘𞖙𞖚𞖛𞖜𞖝𞖞𞖟𞖠𞖡𞖢𞖣𞖤𞖥𞖦𞖧𞖨𞖩𞖪𞖫𞖬𞖭𞖮𞖯𞖰𞖱𞖲𞖳𞖴𞖵𞖶𞖷𞖸𞖹𞖺𞖻𞖼𞖽𞖾𞖿𞗀𞗁𞗂𞗃𞗄𞗅𞗆𞗇𞗈𞗉𞗊𞗋𞗌𞗍𞗎𞗏𞗐𞗑𞗒𞗓𞗔𞗕𞗖𞗗𞗘𞗙𞗚𞗛𞗜𞗝𞗞𞗟𞗠𞗡𞗢𞗣𞗤𞗥𞗦𞗧𞗨𞗩𞗪𞗫𞗬𞗭𞗯𞗮𞗰𞗱𞗲𞗳𞗴𞗵𞗶𞗷𞗸𞗹𞗺𞗻𞗼𞗽𞗾𞗿𞘀𞘁𞘂𞘃𞘄𞘅𞘆𞘇𞘈𞘉𞘊𞘋𞘌𞘍𞘎𞘏𞘐𞘑𞘒𞘓𞘔𞘕𞘖𞘗𞘘𞘙𞘚𞘛𞘜𞘝𞘞𞘟𞘠𞘡𞘢𞘣𞘤𞘥𞘦𞘧𞘨𞘩𞘪𞘫𞘬𞘭𞘮𞘯𞘰𞘱𞘲𞘳𞘴𞘵𞘶𞘷𞘸𞘹𞘺𞘻𞘼𞘽𞘾𞘿𞙀𞙁𞙂𞙃𞙄𞙅𞙆𞙇𞙈𞙉𞙊𞙋𞙌𞙍𞙎𞙏𞙐𞙑𞙒𞙓𞙔𞙕𞙖𞙗𞙘𞙙𞙚𞙛𞙜𞙝𞙞𞙟𞙠𞙡𞙢𞙣𞙤𞙥𞙦𞙧𞙨𞙩𞙪𞙫𞙬𞙭𞙮𞙯𞙰𞙱𞙲𞙳𞙴𞙵𞙶𞙷𞙸𞙹𞙺𞙻𞙼𞙽𞙾𞙿𞚀𞚁𞚂𞚃𞚄𞚅𞚆𞚇𞚈𞚉𞚊𞚋𞚌𞚍𞚎𞚏𞚐𞚑𞚒𞚓𞚔𞚕𞚖𞚗𞚘𞚙𞚚𞚛𞚜𞚝𞚞𞚟𞚠𞚡𞚢𞚣𞚤𞚥𞚦𞚧𞚨𞚩𞚪𞚫𞚬𞚭𞚮𞚯𞚰𞚱𞚲𞚳𞚴𞚵𞚶𞚷𞚸𞚹𞚺𞚻𞚼𞚽𞚾𞚿𞛀𞛁𞛂𞛃𞛄𞛅𞛆𞛇𞛈𞛉𞛊𞛋𞛌𞛍𞛎𞛏𞛐𞛑𞛒𞛓𞛔𞛕𞛖𞛗𞛘𞛙𞛚𞛛𞛜𞛝𞛞𞛟𞛠𞛡𞛢𞛣𞛤𞛥𞛦𞛧𞛨𞛩𞛪𞛫𞛬𞛭𞛮𞛯𞛰𞛱𞛲𞛳𞛴𞛵𞛶𞛷𞛸𞛹𞛺𞛻𞛼𞛽𞛾𞛿𞜀𞜁𞜂𞜃𞜄𞜅𞜆𞜇𞜈𞜉𞜊𞜋𞜌𞜍𞜎𞜏𞜐𞜑𞜒𞜓𞜔𞜕𞜖𞜗𞜘𞜙𞜚𞜛𞜜𞜝𞜞𞜟𞜠𞜡𞜢𞜣𞜤𞜥𞜦𞜧𞜨𞜩𞜪𞜫𞜬𞜭𞜮𞜯𞜰𞜱𞜲𞜳𞜴𞜵𞜶𞜷𞜸𞜹𞜺𞜻𞜼𞜽𞜾𞜿𞝀𞝁𞝂𞝃𞝄𞝅𞝆𞝇𞝈𞝉𞝊𞝋𞝌𞝍𞝎𞝏𞝐𞝑𞝒𞝓𞝔𞝕𞝖𞝗𞝘𞝙𞝚𞝛𞝜𞝝𞝞𞝟𞝠𞝡𞝢𞝣𞝤𞝥𞝦𞝧𞝨𞝩𞝪𞝫𞝬𞝭𞝮𞝯𞝰𞝱𞝲𞝳𞝴𞝵𞝶𞝷𞝸𞝹𞝺𞝻𞝼𞝽𞝾𞝿𞞀𞞁𞞂𞞃𞞄𞞅𞞆𞞇𞞈𞞉𞞊𞞋𞞌𞞍𞞎𞞏𞞐𞞑𞞒𞞓𞞔𞞕𞞖𞞗𞞘𞞙𞞚𞞛𞞜𞞝𞞞𞞟𞞠𞞡𞞢𞞣𞞤𞞥𞞦𞞧𞞨𞞩𞞪𞞫𞞬𞞭𞞮𞞯𞞰𞞱𞞲𞞳𞞴𞞵𞞶𞞷𞞸𞞹𞞺𞞻𞞼𞞽𞞾𞞿𞟀𞟁𞟂𞟃𞟄𞟅𞟆𞟇𞟈𞟉𞟊𞟋𞟌𞟍𞟎𞟏𞟐𞟑𞟒𞟓𞟔𞟕𞟖𞟗𞟘𞟙𞟚𞟛𞟜𞟝𞟞𞟟𞟠𞟡𞟢𞟣𞟤𞟥𞟦𞟧𞟨𞟩𞟪𞟫𞟬𞟭𞟮𞟯𞟰𞟱𞟲𞟳𞟴𞟵𞟶𞟷𞟸𞟹𞟺𞟻𞟼𞟽𞟾𞟿𞠀𞠁𞠂𞠃𞠄𞠅𞠆𞠇𞠈𞠉𞠊𞠋𞠌𞠍𞠎𞠏𞠐𞠑𞠒𞠓𞠔𞠕𞠖𞠗𞠘𞠙𞠚𞠛𞠜𞠝𞠞𞠟𞠠𞠡𞠢𞠣𞠤𞠥𞠦𞠧𞠨𞠩𞠪𞠫𞠬𞠭𞠮𞠯𞠰𞠱𞠲𞠳𞠴𞠵𞠶𞠷𞠸𞠹𞠺𞠻𞠼𞠽𞠾𞠿𞡀𞡁𞡂𞡃𞡄𞡅𞡆𞡇𞡈𞡉𞡊𞡋𞡌𞡍𞡎𞡏𞡐𞡑𞡒𞡓𞡔𞡕𞡖𞡗𞡘𞡙𞡚𞡛𞡜𞡝𞡞𞡟𞡠𞡡𞡢𞡣𞡤𞡥𞡦𞡧𞡨𞡩𞡪𞡫𞡬𞡭𞡮𞡯𞡰𞡱𞡲𞡳𞡴𞡵𞡶𞡷𞡸𞡹𞡺𞡻𞡼𞡽𞡾𞡿𞢀𞢁𞢂𞢃𞢄𞢅𞢆𞢇𞢈𞢉𞢊𞢋𞢌𞢍𞢎𞢏𞢐𞢑𞢒𞢓𞢔𞢕𞢖𞢗𞢘𞢙𞢚𞢛𞢜𞢝𞢞𞢟𞢠𞢡𞢢𞢣𞢤𞢥𞢦𞢧𞢨𞢩𞢪𞢫𞢬𞢭𞢮𞢯𞢰𞢱𞢲𞢳𞢴𞢵𞢶𞢷𞢸𞢹𞢺𞢻𞢼𞢽𞢾𞢿𞣀𞣁𞣂𞣃𞣄𞣅𞣆𞣇𞣈𞣉𞣊𞣋𞣌𞣍𞣎𞣏𞣐𞣑𞣒𞣓𞣔𞣕𞣖𞣗𞣘𞣙𞣚𞣛𞣜𞣝𞣞𞣟𞣠𞣡𞣢𞣣𞣤𞣥𞣦𞣧𞣨𞣩𞣪𞣫𞣬𞣭𞣮𞣯𞣰𞣱𞣲𞣳𞣴𞣵𞣶𞣷𞣸𞣹𞣺𞣻𞣼𞣽𞣾𞣿𞤀𞤁𞤂𞤃𞤄𞤅𞤆𞤇𞤈𞤉𞤊𞤋𞤌𞤍𞤎𞤏𞤐𞤑𞤒𞤓𞤔𞤕𞤖𞤗𞤘𞤙𞤚𞤛𞤜𞤝𞤞𞤟𞤠𞤡𞤢𞤣𞤤𞤥𞤦𞤧𞤨𞤩𞤪𞤫𞤬𞤭𞤮𞤯𞤰𞤱𞤲𞤳𞤴𞤵𞤶𞤷𞤸𞤹𞤺𞤻𞤼𞤽𞤾𞤿𞥀𞥁𞥂𞥃𞥊𞥄𞥅𞥆𞥇𞥈𞥉𞥋𞥌𞥍𞥎𞥏𞥐𞥑𞥒𞥓𞥔𞥕𞥖𞥗𞥘𞥙𞥚𞥛𞥜𞥝𞥞𞥟𞥠𞥡𞥢𞥣𞥤𞥥𞥦𞥧𞥨𞥩𞥪𞥫𞥬𞥭𞥮𞥯𞥰𞥱𞥲𞥳𞥴𞥵𞥶𞥷𞥸𞥹𞥺𞥻𞥼𞥽𞥾𞥿𞦀𞦁𞦂𞦃𞦄𞦅𞦆𞦇𞦈𞦉𞦊𞦋𞦌𞦍𞦎𞦏𞦐𞦑𞦒𞦓𞦔𞦕𞦖𞦗𞦘𞦙𞦚𞦛𞦜𞦝𞦞𞦟𞦠𞦡𞦢𞦣𞦤𞦥𞦦𞦧𞦨𞦩𞦪𞦫𞦬𞦭𞦮𞦯𞦰𞦱𞦲𞦳𞦴𞦵𞦶𞦷𞦸𞦹𞦺𞦻𞦼𞦽𞦾𞦿𞧀𞧁𞧂𞧃𞧄𞧅𞧆𞧇𞧈𞧉𞧊𞧋𞧌𞧍𞧎𞧏𞧐𞧑𞧒𞧓𞧔𞧕𞧖𞧗𞧘𞧙𞧚𞧛𞧜𞧝𞧞𞧟𞧠𞧡𞧢𞧣𞧤𞧥𞧦𞧧𞧨𞧩𞧪𞧫𞧬𞧭𞧮𞧯𞧰𞧱𞧲𞧳𞧴𞧵𞧶𞧷𞧸𞧹𞧺𞧻𞧼𞧽𞧾𞧿𞨀𞨁𞨂𞨃𞨄𞨅𞨆𞨇𞨈𞨉𞨊𞨋𞨌𞨍𞨎𞨏𞨐𞨑𞨒𞨓𞨔𞨕𞨖𞨗𞨘𞨙𞨚𞨛𞨜𞨝𞨞𞨟𞨠𞨡𞨢𞨣𞨤𞨥𞨦𞨧𞨨𞨩𞨪𞨫𞨬𞨭𞨮𞨯𞨰𞨱𞨲𞨳𞨴𞨵𞨶𞨷𞨸𞨹𞨺𞨻𞨼𞨽𞨾𞨿𞩀𞩁𞩂𞩃𞩄𞩅𞩆𞩇𞩈𞩉𞩊𞩋𞩌𞩍𞩎𞩏𞩐𞩑𞩒𞩓𞩔𞩕𞩖𞩗𞩘𞩙𞩚𞩛𞩜𞩝𞩞𞩟𞩠𞩡𞩢𞩣𞩤𞩥𞩦𞩧𞩨𞩩𞩪𞩫𞩬𞩭𞩮𞩯𞩰𞩱𞩲𞩳𞩴𞩵𞩶𞩷𞩸𞩹𞩺𞩻𞩼𞩽𞩾𞩿𞪀𞪁𞪂𞪃𞪄𞪅𞪆𞪇𞪈𞪉𞪊𞪋𞪌𞪍𞪎𞪏𞪐𞪑𞪒𞪓𞪔𞪕𞪖𞪗𞪘𞪙𞪚𞪛𞪜𞪝𞪞𞪟𞪠𞪡𞪢𞪣𞪤𞪥𞪦𞪧𞪨𞪩𞪪𞪫𞪬𞪭𞪮𞪯𞪰𞪱𞪲𞪳𞪴𞪵𞪶𞪷𞪸𞪹𞪺𞪻𞪼𞪽𞪾𞪿𞫀𞫁𞫂𞫃𞫄𞫅𞫆𞫇𞫈𞫉𞫊𞫋𞫌𞫍𞫎𞫏𞫐𞫑𞫒𞫓𞫔𞫕𞫖𞫗𞫘𞫙𞫚𞫛𞫜𞫝𞫞𞫟𞫠𞫡𞫢𞫣𞫤𞫥𞫦𞫧𞫨𞫩𞫪𞫫𞫬𞫭𞫮𞫯𞫰𞫱𞫲𞫳𞫴𞫵𞫶𞫷𞫸𞫹𞫺𞫻𞫼𞫽𞫾𞫿𞬀𞬁𞬂𞬃𞬄𞬅𞬆𞬇𞬈𞬉𞬊𞬋𞬌𞬍𞬎𞬏𞬐𞬑𞬒𞬓𞬔𞬕𞬖𞬗𞬘𞬙𞬚𞬛𞬜𞬝𞬞𞬟𞬠𞬡𞬢𞬣𞬤𞬥𞬦𞬧𞬨𞬩𞬪𞬫𞬬𞬭𞬮𞬯𞬰𞬱𞬲𞬳𞬴𞬵𞬶𞬷𞬸𞬹𞬺𞬻𞬼𞬽𞬾𞬿𞭀𞭁𞭂𞭃𞭄𞭅𞭆𞭇𞭈𞭉𞭊𞭋𞭌𞭍𞭎𞭏𞭐𞭑𞭒𞭓𞭔𞭕𞭖𞭗𞭘𞭙𞭚𞭛𞭜𞭝𞭞𞭟𞭠𞭡𞭢𞭣𞭤𞭥𞭦𞭧𞭨𞭩

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682 ।

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 1-800-552-2682.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajujụ 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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、1-800-552-2682 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ 1-800-552-2682 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-800-552-2682.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-800-552-2682 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມເປພາສາ, ໃຫ້ໂທຫາ 1-800-552-2682.

Navajo (Diné): Dít naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee níl hodoonih t'áadoo báąh ilinígóó.
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojį' hodiłilnih 1-800-552-2682.

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 1-800-552-2682

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-800-552-2682 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-800-552-2682 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-552-2682.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 1-800-552-2682.

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, 1-800-552-2682 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

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Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totagi. Ina ia talanoa i se tagata faaliliu, vili 1-800-552-2682.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite 1-800-552-2682.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 1-800-552-2682.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang 1-800-552-2682.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-800-552-2682 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: 1-800-552-2682.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، 1-800-552-2682 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 1-800-552-2682.

(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 1-800-552-2682.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọ́fẹ́ẹ̀. Bá wa ògbùfọ̀ kan sọrọ̀, pe 1-800-552-2682.

Language Access Services:

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