



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 871-4901 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,300/individual or<br>\$3,900/employee + children or<br>\$3,900/family for In- <a href="#">Network Providers</a> .<br>\$2,600/individual or<br>\$7,800/employee + children or<br>\$7,800/family for Out-of- <a href="#">Network Providers</a> .    | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                      |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .                                                                                                                                                                      | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                   | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,050/individual or<br>\$9,750/employee + children or<br>\$9,750/family for In- <a href="#">Network Providers</a> .<br>\$12,150/individual or<br>\$29,250/employee + children or<br>\$29,250/family for Out-of- <a href="#">Network Providers</a> . | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                       |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Will you pay less if you use a <a href="#">network</a>                          | Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855)                                                                                                                                                              | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive                                                                                                                                                                                                                                                                                            |

|                                                                              |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <a href="#">provider</a> ?                                                   | 871-4901 for a list of <a href="#">network providers</a> . | a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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> .                                                                                                                                                                                                                                                                                                        |



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

| Common Medical Event                                                                                                                                                                                       | Services You May Need                                                               | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                            |                                                                                     | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                     | Primary care visit to treat an injury or illness                                    | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                            | <a href="#">Specialist</a> visit                                                    | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                            | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization           | No charge                                       | 50% <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> (lab work)**                                        | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | **Lab work is covered at 100% if done at LabCorp, Quest Diagnostic/LabCard or American Health Network                                                                                     |
|                                                                                                                                                                                                            | <a href="#">Diagnostic test</a> (x-ray)                                             | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                            | Imaging (CT/PET scans, MRIs)                                                        | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.caremark.com</a> or by visiting the BSU website. | Tier 1 - Typically Generic                                                          | Not covered                                     | Not covered                                        | Carved out to CVS/Caremark                                                                                                                                                                |
|                                                                                                                                                                                                            | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | Not covered                                     | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                            | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | Not covered                                     | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                            | Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)                    | Not covered                                     | Not covered                                        |                                                                                                                                                                                           |
| If you have outpatient surgery                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)                                      | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |
|                                                                                                                                                                                                            | Physician/surgeon fees                                                              | 20% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                    | -----none-----                                                                                                                                                                            |

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

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                   |                                                     | Limitations, Exceptions, & Other Important Information                                          |
|---------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)     | Out-of-Network Provider<br>(You will pay the most)  |                                                                                                 |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$200/visit then 20% <a href="#">coinsurance</a>    | Covered as In- <a href="#">Network</a>              | Copay waived if admitted.                                                                       |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                     | Covered as In- <a href="#">Network</a>              | -----none-----                                                                                  |
|                                                                           | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>20% <a href="#">coinsurance</a>     | Office Visit<br>50% <a href="#">coinsurance</a>     | Office Visit<br>-----none-----                                                                  |
|                                                                           |                                                  | Other Outpatient<br>20% <a href="#">coinsurance</a> | Other Outpatient<br>50% <a href="#">coinsurance</a> | Other Outpatient<br>-----none-----                                                              |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     |                                                                                                 |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     |                                                                                                 |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
|                                                                           | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | *See Therapy Services section                                                                   |
|                                                                           | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     |                                                                                                 |
|                                                                           | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
|                                                                           | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a>                     | 20% <a href="#">coinsurance</a>                     | *See <a href="#">Durable Medical Equipment</a> Section                                          |
|                                                                           | <a href="#">Hospice services</a>                 | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | -----none-----                                                                                  |
| If your child needs dental or eye care                                    | Children's eye exam                              | 20% <a href="#">coinsurance</a>                     | 50% <a href="#">coinsurance</a>                     | *See Vision Services section                                                                    |
|                                                                           | Children's glasses                               | Not covered                                         | Not covered                                         |                                                                                                 |
|                                                                           | Children's dental check-up                       | Not covered                                         | Not covered                                         | *See Dental Services section                                                                    |

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

## Excluded Services & Other Covered Services:

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

- |                                                                                       |                                                                    |                                                        |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------|
| • Acupuncture                                                                         | • Cosmetic surgery                                                 | • Dental care (adult)                                  |
| • Dental Check-up                                                                     | • Glasses for a child                                              | • Hearing aids                                         |
| • Infertility treatment                                                               | • Long- term care                                                  | • Routine eye care (adult)                             |
| • Routine foot care unless you have been diagnosed with diabetes.                     | • Tier 1 - Typically Generic                                       | • Tier 2 - Typically <a href="#">Preferred</a> / Brand |
| • Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | • Tier 4 - Typically <a href="#">Specialty</a> (brand and generic) | • Weight loss programs                                 |

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

- |                                                                                                                            |                        |                                               |
|----------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------|
| • Abortion                                                                                                                 | • Bariatric surgery    | • Chiropractic care 24 visits/benefit period. |
| • Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> | • Private-duty nursing |                                               |

**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, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 105568, Atlanta GA 30348-5568

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

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

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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,300 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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 |
|--------------------|----------|

|                                 |         |
|---------------------------------|---------|
| In this example, Peg would pay: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$1,300 |
| <a href="#">Copayments</a>      | \$0     |
| <a href="#">Coinsurance</a>     | \$2,520 |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$96    |
| The total Peg would pay is      | \$3,916 |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,300 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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 |
|--------------------|---------|

|                                 |         |
|---------------------------------|---------|
| In this example, Joe would pay: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$959   |
| <a href="#">Copayments</a>      | \$0     |
| <a href="#">Coinsurance</a>     | \$240   |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$6,041 |
| The total Joe would pay is      | \$7,239 |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,300 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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 | \$2,010 |
|--------------------|---------|

|                                 |         |
|---------------------------------|---------|
| In this example, Mia would pay: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$1,300 |
| <a href="#">Copayments</a>      | \$0     |
| <a href="#">Coinsurance</a>     | \$385   |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,685 |

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

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 871-4901

[illegible]

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 871-4901 (855).

**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) 871-4901:

**Bassa (Bàsɔ̀ Wùdù):** M̃ dyi dyi-diè-dɛ bɛ́ bédé bá cée-dɛ nìà kɛ dyí ní, ɔ̀ mò nì dyí-bèdɛ̀n-dɛ bɛ́ m̃ kɛ gbo-kpá-kpá kè b̃́ kp̃́ dɛ m̃ bídí-wùdù̀n bó pídyi. Bɛ́ m̃ kɛ wudu-zìin-nyò dò gbo wùdù kɛ, d́á (855) 871-4901.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 871-4901 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 871-4901 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) 871-4901。

**Dinka (Dinka):** Na nŋ thiēc nē ke de yā thorē, ke yin nŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (855) 871-4901.

**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) 871-4901.

**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 871-4901 (855) 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) 871-4901.



## 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) 871-4901.

**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) 871-4901.

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