




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, go to [hr2.chevron.com](http://hr2.chevron.com) or contact the Chevron Human Resources Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.). 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 1-844-627-1632 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>For Medical, Prescription Drug, and Mental Health and Substance Use Disorder combined.</p> <p>For <a href="#">network providers</a>.</p> <p><b>\$3,200</b> You Only  <b>\$6,400</b> You and One Adult/<b>\$3,200</b> Per Person  <b>\$6,400</b> You and Child(ren)/<b>\$3,200</b> Per Person  <b>\$6,400</b> You and Family/<b>\$3,200</b> Per Person</p> <p>For <a href="#">out-of-network providers</a>.</p> <p><b>\$6,400</b> You Only  <b>\$12,800</b> You and One Adult/<b>\$6,400</b> Per Person  <b>\$12,800</b> You and Child(ren)/<b>\$6,400</b> Per Person  <b>\$12,800</b> You and Family/<b>\$6,400</b> Per Person</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> for <a href="#">network providers</a> are covered before you meet your deductible. <a href="#">Deductible</a> does not apply to certain <a href="#">preventive care</a> in <a href="#">network</a> services as specified by the Affordable Care Act.</p> <p>The following are a few major exceptions that do not count toward the <a href="#">deductible</a>: charges in excess of contracted rate/<a href="#">allowed amount</a> by an <a href="#">out-of-network provider</a> (balanced billed charges); your share of costs and expenses under the Vision Program; charges that aren't covered or <a href="#">medically necessary</a> under the <a href="#">plan</a>; penalties for non-compliance; health care this <a href="#">plan</a> doesn't cover; the difference between cost of generic and brand-name drug; the difference between the network and the out-of-network pharmacy price (including when you don't provide your ID card at a network pharmacy); charges that aren't covered by the plan.</p>	<p>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 <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>

<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For Medical, Prescription Drug, and Mental Health and Substance Use Disorder combined:</p> <p>For <a href="#">network providers</a>  <b>\$5,000</b> You Only  <b>\$10,000</b> You and One Adult/<b>\$5,000</b> Per Person  <b>\$10,000</b> You and Child(ren)/<b>\$5,000</b> Per Person  <b>\$10,000</b> You and Family/<b>\$5,000</b> Per Person</p> <p>For <a href="#">out-of-network providers</a>  <b>\$10,000</b> You Only  <b>\$20,000</b> You and One Adult/<b>\$10,000</b> Per Person  <b>\$20,000</b> You and Child(ren)/<b>\$10,000</b> Per Person  <b>\$20,000</b> You and Family/<b>\$10,000</b> Per Person</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>The following are a few major exceptions that do not count toward the medical <a href="#">out-of-pocket limit</a>: <a href="#">premiums</a>; difference between the cost of generic and brand name drugs; additional <a href="#">coinsurance</a> amount when you go to a retail <a href="#">network</a> pharmacy after the first refill of a prescription for maintenance medications; your share of costs and expenses under the Vision Program; charges that aren't deemed <a href="#">medically necessary</a> under the <a href="#">plan</a>; penalties for failure to obtain <a href="#">pre-authorization</a> for services; charges in excess of contracted rate/<a href="#">allowed amount</a> by an <a href="#">out-of-network provider</a> (<a href="#">balance billed</a> charges) and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes, BlueCard PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-844-627-1632 for a list of <a href="#">network providers</a>.</p>	<p>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 <a href="#">out-of-network provider</a>, and you might receive 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 <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [hr2.chevron.com](http://hr2.chevron.com) or call 1-888-825-5247 for a copy.

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	If you receive services in addition to an office visit, additional <a href="#">copayment</a> , <a href="#">deductibles</a> , or <a href="#">coinsurance</a> may apply.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	Immunizations for travel not covered. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need 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)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by calling Express Scripts at 1-800-987-8368 or going to <a href="#">www.express-scripts.com</a>	Generic drugs	Retail: <b>\$5 copay</b> after <a href="#">deductible</a> . Mail Order: <b>\$15 copay</b> after <a href="#">deductible</a> .	<b>Retail:</b> Not covered. <b>Mail order:</b> Not covered.	Must meet the deductible before you plan will share in the cost of your medication. Certain items identified by your plan as preventative care are covered in full and not subject to the <a href="#">copay</a> or <a href="#">deductible</a> amounts indicated. Covers up to 30 day supply (retail prescription); 90 supply (mail-order prescription). Your <a href="#">plan</a> uses a preferred drug list, also referred to as a <a href="#">formulary</a> , which identifies the status of covered drugs. Some drugs may require pre-authorization. If the necessary <a href="#">preauthorization</a> is not obtained, the drug may not be covered. Your <a href="#">plan</a> uses utilization management programs that require you try one or more drugs before another drug will be covered.
	Preferred Brand drugs	Retail: <b>20% coinsurance</b> after <a href="#">deductible</a> with <b>\$15</b> minimum <a href="#">copay</a> . Mail Order: <b>15% coinsurance</b> with <b>\$35</b> minimum <a href="#">copay</a> after <a href="#">deductible</a> .		
	Non-Preferred Brand drugs	Retail: <b>30% coinsurance</b> after <a href="#">deductible</a> with <b>\$30</b> minimum <a href="#">copay</a> . Mail Order: <b>25% coinsurance</b> with <b>\$75</b> minimum <a href="#">copay</a> after <a href="#">deductible</a> .		
	<a href="#">Specialty drugs</a>	See Generic, Preferred brand, and Non-preferred		

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [hr2.chevron.com](#) or call 1-888-825-5247 for a copy.

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)	
		brand drugs above for cost information.		Your <a href="#">plan</a> may limit the quantity of a covered drug. You pay the difference in cost if you request a brand name drug instead of its generic equivalent. After a prescription for a non-specialty drug is filled 2 times at retail, a 60% retail <a href="#">coinsurance</a> and applicable minimum copay apply. Refills for Specialty Maintenance Drugs only available through mail-order. Certain <a href="#">specialty drug</a> require first fill at Express Scripts specialty pharmacy (Accredo). For a list of these drugs, contact Express Scripts at 1-800-987-8368.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-notification is required. If you don't get <a href="#">pre-authorization</a> , coinsurance amounts could be reduced.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Benefits may be provided by the Mental Health and Substance Use Disorder Plan. For more information, go to <a href="http://hr2.chevron.com">hr2.chevron.com</a> , or call 1-800-847-2438 (714-763-2420 outside the U.S.).
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [hr2.chevron.com](http://hr2.chevron.com) or call 1-888-825-5247 for a copy.

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)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-notification required; limited to 60 visits per calendar year; combined network and <a href="#">out-of-network</a> . If you don't get <a href="#">pre-authorization</a> , coinsurance amounts could be reduced.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	90 visits combined maximum for physical, occupational and speech therapies per calendar year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	No coverage for <a href="#">Habilitation services</a>
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-notification required; 120 days per calendar year. If you don't get <a href="#">pre-authorization</a> , coinsurance amounts could be reduced.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-notification required for any item with a purchase price or cumulative rental price above \$1,000. If you don't get <a href="#">pre-authorization</a> , coinsurance amounts could be reduced.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-notification required. If you don't get <a href="#">pre-authorization</a> , coinsurance amounts could be reduced.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Benefits may be provided by the Chevron Corporation Vision Program. For more information, go to <a href="http://hr2.chevron.com">hr2.chevron.com</a> , or call 1-800-877-7195 (1-916-851-5000 outside the U.S.).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up under this <a href="#">plan</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [hr2.chevron.com](http://hr2.chevron.com) or call 1-888-825-5247 for a copy.

## 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
- Dental Care (adult and child)
- Glasses (adult and child)
- [Habilitation services](#)
- Long term care
- Mental health, behavioral health and substance abuse
- Routine eye care (adult and child)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

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

- Acupuncture 20 visits/calendar year
- Bariatric surgery
- Chiropractic care 20 visits/calendar year
- Hearing aids \$5,000 maximum every 4 years
- Family planning and infertility services \$60,000 maximum/lifetime - combined medical and prescription drugs
- Non-emergency care when traveling outside the U.S. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Private Duty Nursing 1,000 hours or 120 days/calendar year

**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 Labor, Employee Benefits Security Administration, 1866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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: [Grievances](#) and [Appeals](#), P.O. Box 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

### 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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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>	\$3,200
▮ <a href="#">Specialist copayment</a>	20%
▮ Hospital (facility) <a href="#">coinsurance</a>	20%
▮ Other <a href="#">coinsurance</a>	20%

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,120</b>

### 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>	\$3,200
▮ <a href="#">Specialist copayment</a>	20%
▮ Hospital (facility) <a href="#">coinsurance</a>	20%
▮ Other <a href="#">coinsurance</a>	20%

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,300</b>

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

▮ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
▮ <a href="#">Specialist copayment</a>	20%
▮ Hospital (facility) <a href="#">coinsurance</a>	20%
▮ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.  
 Where a conflict exists between this SBC and the [plan](#) document, the [plan](#) document controls.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë document, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-844-1-844-627-1632

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-844-627-1632 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-844-627-1632.

**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՝ 1-844-627-1632:

**Bassa (Básò Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édé b̄á céè-djè nià ke dyí ní, ɔ m̄ò ni dyí-b̄édjèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̄ bídí-wùdùùñ b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò djò gbo wùdù ke, dá 1-844-627-1632.

**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 1-844-627-1632 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-844-627-1632 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 1-844-627-1632。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cəl 1-844-627-1632.

**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 1-844-627-1632.



## Language Access Services:

**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 1-844-627-1632 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 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632 ।

**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 1-844-627-1632.

**Igbo (Igbo):** O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ o bụla. Ka gi na okọwa okwu kwuo okwu, kpọọ 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

## Language Access Services:

**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 1-844-627-1632

**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、1-844-627-1632 にお電話ください。

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ 1-844-627-1632 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-844-627-1632.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-844-627-1632 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໄວ້ວັນກັບວ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-844-627-1632.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehjǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojǫ́' hodiilnih 1-844-627-1632.

**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 1-844-627-1632

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-844-627-1632 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 1-844-627-1632 aa.

## Language Access Services:

**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 1-844-627-1632.

**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 1-844-627-1632.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-844-627-1632 ਤੇ ਕਾਲ ਕਰੋ।

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic 1-844-627-1632.

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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 totogi. Ina ia talanoa i se tagata faaliliu, vili 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

**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 1-844-627-1632.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-844-627-1632 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 1-844-627-1632.

## Language Access Services:

**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، 1-844-627-1632 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 1-844-627-1632.

**(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 1-844-627-1632.

**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 sọ̀rọ̀, pe 1-844-627-1632.

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