



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 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/ or call 1-844-627-1632 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For Medical, Prescription Drug, and Behavioral Health (Mental Health and Substance Use Disorder) combined. For network providers. \$3,400 You Only \$6,800 You and One Adult/\$3,400 Per Person \$6,800 You and Child(ren)/\$3,400 Per Person \$6,800 You and Family/\$3,400 Per Person For out-of-network providers. \$6,800 You Only \$13,600 You and One Adult/\$6,800 Per Person \$13,600 You and Child(ren)/\$6,800 Per Person \$13,600 You and Family/\$6,800 Per Person	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 care for network providers are covered before you meet your deductible. Deductible does not apply to certain preventive care in network services as specified by the Affordable Care Act. The following are a few major exceptions that do not count toward the deductible: charges in excess of contracted rate/allowed amount by an out-of-network provider (balanced billed charges); your share of costs and expenses under the Vision Program; charges that aren't covered or medically necessary under the plan; penalties for non-compliance; health care this plan 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); and charges that aren't covered by the plan.	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 ?	For Medical, Prescription Drug, and Behavioral Health (Mental Health and Substance Use Disorder) combined: For network providers \$5,000 You Only \$10,000 You and One Adult/\$5,000 Per Person \$10,000 You and Child(ren)/\$5,000 Per Person \$10,000 You and Family/\$5,000 Per Person For out-of-network providers \$10,000 You Only \$20,000 You and One Adult/\$10,000 Per Person \$20,000 You and Child(ren)/\$10,000 Per Person \$20,000 You and Family/\$10,000 Per Person	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 ?	The following are a few major exceptions that do not count toward the medical out-of-pocket limit : premiums ; difference between the cost of generic and brand name drugs;; your share of costs and expenses under the Vision Program; charges that aren't deemed medically necessary under the plan ; penalties for failure to obtain pre-authorization for services; charges in excess of contracted rate/ allowed amount by an out-of-network provider (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, BlueCard PPO. See www.anthem.com/ca or call 1-844--627-1632 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-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	20% coinsurance	40% coinsurance	If you receive services in addition to an office visit, additional copayment , deductibles , or coinsurance may apply.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	Immunizations for travel not covered. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling Express Scripts at 1-800-987-8368 or going to www.express-scripts.com	Generic drugs	Retail: \$5 copay after deductible . Mail Order: \$15 copay after deductible .	Retail: \$5 copay after deductible . Mail order: Not covered.	Must meet the deductible before you plan will share in the cost of your medication. When you use an out-of-network retail pharmacy, you pay the approved retail price minus the required coinsurance/copayment for your prescription after an approved claim for reimbursement. Certain items identified by your plan as preventative care are covered in full and not subject to the copay or deductible amounts indicated. Covers up to 30 day supply (retail prescription); 90 supply (mail-order prescription).
	Preferred Brand drugs	Retail: 20% coinsurance after deductible with \$15 minimum copay . Mail Order: 15% coinsurance with \$35 minimum copay after deductible .	Retail: 20% coinsurance after deductible with \$15 minimum copay . Mail Order: Not covered	

* 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)	
	Non-Preferred Brand drugs	Retail: 30% coinsurance after deductible with \$30 minimum copay . Mail Order: 25% coinsurance with \$75 minimum copay after deductible .	Retail: 30% coinsurance after deductible with \$30 minimum copay . Mail Order: Not covered	Your plan uses a preferred drug list, also referred to as a formulary , which identifies the status of covered drugs. Some drugs may require pre-authorization. If the necessary preauthorization is not obtained, the drug may not be covered. Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered. Your plan 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. Refills for Specialty Drugs only available through mail-order Certain specialty drug require first fill at Express Scripts specialty pharmacy (Accredo). For a list of these drugs, contact Express Scripts at 1-800-987-8368.
	Specialty drugs	See Generic, Preferred brand, and Non-preferred brand drugs above for cost information.	Retail: Not covered. Mail order: Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-notification is required. If you don't get pre-authorization , coinsurance amounts could be reduced.

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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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Mental health, behavioral health, and substance use services apply to the Medical deductible and out-of-pocket maximum.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-notification required; limited to 60 visits per calendar year; combined network and out-of-network . If you don't get pre-authorization , coinsurance amounts could be reduced.
	Rehabilitation services	20% coinsurance	40% coinsurance	90 visits combined maximum for physical, occupational and speech therapies per calendar year.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-notification required; 120 days per calendar year. If you don't get pre-authorization , coinsurance amounts could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-notification required for any item with a purchase price or cumulative rental price above \$1,000. If you don't get pre-authorization , coinsurance amounts could be reduced.

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)	
	Hospice services	20% coinsurance	40% coinsurance	Pre-notification required. If you don't get pre-authorization , coinsurance amounts could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Benefits may be provided by the Chevron Corporation Vision Program. For more information, go to hr2.chevron.com , 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 plan .

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 •	• 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 • 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, 1-866-444-EBSA (3272), 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 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

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.

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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	\$3,400
▮ Specialist copayment	20%
▮ Hospital (facility) coinsurance	20%
▮ Other coinsurance	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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,400
Copayments	\$20
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,320

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

▮ The plan's overall deductible	\$3,400
▮ Specialist copayment	20%
▮ Hospital (facility) coinsurance	20%
▮ Other coinsurance	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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,400
Copayments	\$300
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,500

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

▮ The plan's overall deductible	\$3,400
▮ Specialist copayment	20%
▮ Hospital (facility) coinsurance	20%
▮ Other coinsurance	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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

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 bụr ụ na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusụ gi na akwughị ugwo o bula. Ka gi na okowa 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. ເພື່ອໄວ້ວົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-844-627-1632.

Navajo (Diné): Dii naaltsoos bika'ígíí lahgo bina'idíilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih 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 kamiyyuu 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 griegie 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 ਦੁਭਾਸ਼ੀਏ 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 leni 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.

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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

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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 rẹ lọfẹ́ẹ̀. Bá wa ògbùfọ̀ kan sọrọ̀, pe 1-844-627-1632.

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