



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/fi>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (833) 772-4121 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$1,000/person or \$2,000/family. All <a href="#">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</a> and Non- <a href="#">Network</a> <a href="#">Providers</a> . Primary Care <a href="#">Specialist</a> Visit for In- <a href="#">Network</a> <a href="#">Providers</a> . Tier 1a Tier 1b Tier 2 Tier 3 Tier 4 <a href="#">Prescription Drugs</a> for In- <a href="#">Network</a> and Non- <a href="#">Network</a> <a href="#">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 <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> . |
| 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> ? | \$8,550/person or \$17,100/family. All <a href="#">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 provider</a> ?               | Yes, National PPO (BlueCard PPO). See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 772-4121 for a list of <a href="#">network providers</a> .  | 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. |
| 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)  | Non-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/visit <a href="#">deductible</a> does not apply   | 40% <a href="#">coinsurance</a>  | -----none-----  |
|   | <a href="#">Specialist</a> visit  | \$30/visit <a href="#">deductible</a> does not apply   | 40% <a href="#">coinsurance</a>  | -----none-----  |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization | No charge  | 20% <a href="#">coinsurance</a> <a href="#">deductible</a> does not apply  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)                       | 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>  | -----none-----  |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br><br>National Drug List | Tier 1a - Typically Lower Cost Generic                                    | \$10/prescription, <a href="#">deductible</a> does not apply (retail) and \$20/prescription, <a href="#">deductible</a> does not apply (home delivery) | \$10/prescription, <a href="#">deductible</a> does not apply (retail) and \$20/prescription, <a href="#">deductible</a> does not apply (home delivery) | *See Prescription Drug section  |
|   | Tier 1b - Typically Generic   | \$15/prescription, <a href="#">deductible</a> does not apply (retail) and \$30/prescription, <a href="#">deductible</a> does not apply (home delivery) | \$15/prescription, <a href="#">deductible</a> does not apply (retail) and \$30/prescription, <a href="#">deductible</a> does not apply (home delivery) |   |
|   | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs          | \$35/prescription, <a href="#">deductible</a> does not apply (retail) and \$70/prescription, <a href="#">deductible</a> does not apply (home delivery) | \$35/prescription, <a href="#">deductible</a> does not apply (retail) and \$70/prescription, <a href="#">deductible</a> does not apply (home delivery) |   |

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

| 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)   | Non-Network Provider<br>(You will pay the most)   |   |
|   | Tier 3 - Typically Non-Preferred Brand and Generic drugs   | \$60/prescription, <a href="#">deductible</a> does not apply (retail) and \$120/prescription, <a href="#">deductible</a> does not apply (home delivery) | \$60/prescription, <a href="#">deductible</a> does not apply (retail) and \$120/prescription, <a href="#">deductible</a> does not apply (home delivery) |   |
|   | Tier 4 - Typically Preferred Specialty (brand and generic) | \$85/prescription, <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery)   | \$85/prescription, <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery)   |   |
| 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>   | -----none-----  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                        | \$200/visit <a href="#">deductible</a> does not apply   | 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/visit <a href="#">deductible</a> does not apply  | 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>   | 150 days/year for Inpatient rehabilitation and skilled nursing services combined.               |
|   | 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  | Office Visit \$20/visit <a href="#">deductible</a> does not apply<br>Other Outpatient 20% <a href="#">coinsurance deductible</a> does not apply         | Office Visit 40% <a href="#">coinsurance</a><br>Other Outpatient 40% <a href="#">coinsurance deductible</a> does not apply                              | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----                            |
|   | Inpatient services   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | -----none-----  |
| If you are pregnant   | Office visits  | \$30/ visit <a href="#">deductible</a> does not apply   | 40% <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>   | 40% <a href="#">coinsurance</a>   |   |
|   | Childbirth/delivery facility services                      | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   |   |
| If you need help recovering or  | <a href="#">Home health care</a>                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | -----none-----  |
|   | <a href="#">Rehabilitation services</a>                    | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | *See Therapy Services section.  |

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

| 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) | Non-Network Provider<br>(You will pay the most)           |   |
| have other special health needs        | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                           |   |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                           | 150 days/year for Inpatient rehabilitation and skilled nursing services combined. |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                           | *See <a href="#">Durable Medical Equipment</a> Section                            |
|  | <a href="#">Hospice services</a>          | No charge                                       | 20% <a href="#">coinsurance deductible</a> does not apply | -----none-----  |
| If your child needs dental or eye care | Children's eye exam                       | Not covered                                     | Not covered   | *See Vision Services section  |
|  | Children's glasses                        | Not covered                                     | Not covered   |   |
|  | Children's dental check-up                | Not covered                                     | Not covered   | *See Dental Services section  |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other excluded services.) |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>                  | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Pediatric)</li> <li>• Long-term care</li> <li>• Routine foot care unless you have been diagnosed with diabetes. Exceptions in the case of vascular or systemic disease.</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture 20 visits/year</li> <li>• Hearing aids</li> </ul>                                       | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care 40 visits/year</li> </ul> |

**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: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). 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](#)

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

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 218, North Haven, CT 06473-0218

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

Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, (800) 300-5000

Consumers for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490, (800) 965-7476, [www.maine cahc.org](http://www.maine cahc.org), [consumerhealth@maine cahc.org](mailto:consumerhealth@maine cahc.org)

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

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

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

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

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

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

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.

|  |   |  |
|--|---|--|
| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal care and a hospital delivery) | <b>Managing Joe’s Type 2 Diabetes</b><br>(a year of routine in-network care of a well-controlled condition) | <b>Mia’s Simple Fracture</b><br>(in-network emergency room visit and follow up care) |
|--|---|--|

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>■ The <a href="#">plan’s</a> overall <a href="#">deductible</a> <span style="float: right;">\$1,000</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$30</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> </ul> | <ul style="list-style-type: none"> <li>■ The <a href="#">plan’s</a> overall <a href="#">deductible</a> <span style="float: right;">\$1,000</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$30</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> </ul> | <ul style="list-style-type: none"> <li>■ The <a href="#">plan’s</a> overall <a href="#">deductible</a> <span style="float: right;">\$1,000</span></li> <li>■ <a href="#">Specialist copayment</a> <span style="float: right;">\$30</span></li> <li>■ Hospital (facility) <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> <li>■ Other <a href="#">coinsurance</a> <span style="float: right;">20%</span></li> </ul> |
|--|--|--|

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*)

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*)

This EXAMPLE event includes services like:

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

|                           |                 |                           |                |                           |                |
|---------------------------|-----------------|---------------------------|----------------|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> | <b>Total Example Cost</b> | <b>\$5,600</b> | <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|-----------------|---------------------------|----------------|---------------------------|----------------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$40           |
| <a href="#">Coinsurance</a>       | \$1,800        |
| <i>What isn’t covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,900</b> |

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$100          |
| <a href="#">Copayments</a>        | \$1,300        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn’t covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,420</b> |

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn’t covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |

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

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 772-4121

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 772-4121 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 (833) 772-4121.

**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՝ (833) 772-4121:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀in-dɛ̀ bɛ̀ m̀ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ b́í d́í-wùdùùn b́ó ṕídyi. B́é m̀ kɛ̀ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (833) 772-4121.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 772-4121 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (833) 772-4121 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(833) 772-4121。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833) 772-4121.

**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 (833) 772-4121.

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## Language Access Services:

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**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 (833) 772-4121.

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## Language Access Services:

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## Language Access Services:

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