



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/9ZG6SMG01012024>. 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) 748-1805 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000/person or \$3,000/family for In- <a href="#">Network Providers</a> . \$2,000/person or \$6,000/family for Non- <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. Primary Care. <a href="#">Specialist Visit</a> . <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . Vision. For more information see below.	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> ?	\$7,500/person or \$15,000/family for In- <a href="#">Network Providers</a> . \$15,000/person or \$30,000/family for Non- <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 provider</a> ?	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=N7H">www.anthem.com/find-care/?alphaprefix=N7H</a> or call (855) 748-1805 for a list of <a href="#">network providers</a> . Benefits may be limited by Site of Service. Costs may vary by site of service	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.

	and how the <a href="#">provider</a> bills.	
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Not Applicable	PPC No charge PCP \$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Please see <a href="http://www.anthem.com">http://www.anthem.com</a> for a list of <a href="#">Preferred Primary Care (PPC) Providers</a> . Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	Not Applicable	\$40/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	Not Applicable	No charge	40% <a href="#">coinsurance</a>	Prescribed FDA approved contraceptives are not subject to cost shares. 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office No charge X-Ray – Office 20% <a href="#">coinsurance</a>	Lab – Office 40% <a href="#">coinsurance</a> X-Ray – Office 40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is	Typically Lower Cost Generic (Tier 1a)	\$2/prescription, <a href="#">deductible</a> does not apply (retail) and \$4/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$12/prescription, <a href="#">deductible</a> does not apply (retail only)	50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)	For more information, refer to “Select Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug section

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9ZG6SMG01012024>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1b)	\$20/prescription, <a href="#">deductible</a> does not apply (retail) and \$40/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$30/prescription, <a href="#">deductible</a> does not apply (retail only)	50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)	
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$60/prescription, <a href="#">deductible</a> does not apply (retail) and \$120/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$70/prescription, <a href="#">deductible</a> does not apply (retail only)	50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	30% <a href="#">coinsurance</a> up to \$400/prescription, <a href="#">deductible</a> does not apply (retail) and 30% <a href="#">coinsurance</a> up to \$800/prescription, <a href="#">deductible</a> does not apply (home delivery)	40% <a href="#">coinsurance</a> up to \$500/prescription, <a href="#">deductible</a> does not apply (retail only)	50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)	
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	40% <a href="#">coinsurance</a> up to \$550/prescription, <a href="#">deductible</a> does not apply (retail and home delivery)	50% <a href="#">coinsurance</a> up to \$650/prescription, <a href="#">deductible</a> does not apply (retail only)	50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail only)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$250/visit <a href="#">deductible</a> does not apply for Ambulatory Surgical Center for In- <a href="#">Network Providers</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9ZG6SMG01012024>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not Applicable	\$350/visit	Covered as In- <a href="#">Network</a>	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	Not Applicable	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	Non-emergency Non- <a href="#">Network</a> Ambulance Services are limited to \$50,000 per trip.
	<a href="#">Urgent care</a>	Not Applicable	\$100/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	In- <a href="#">Network</a> <a href="#">Urgent Care</a> benefit limited to preferred New Hampshire locations.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs for In- <a href="#">Network</a> and Non- <a href="#">Network</a> <a href="#">Providers</a> combined.
	Physician/surgeon fees	Not Applicable	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 Applicable	Office Visit \$20/visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for In- <a href="#">Network</a> <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Postpartum office visits are part of the professional maternity services.
	Childbirth/delivery professional services	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9ZG6SMG01012024>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Rehabilitation services</a>	Not Applicable	\$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	Not Applicable	\$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days/benefit period for skilled nursing services for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	Not Applicable	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	Not Applicable	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	\$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a>	*See Vision Services section
	Children's glasses	Not Applicable	No charge	\$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a>	
	Children's dental check-up	Not Applicable	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	*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 <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Routine foot care unless <a href="#">medically necessary</a></li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Weight loss programs</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>• Abortion</li> <li>• Chiropractic care 36 visits/benefit period</li> </ul>	<ul style="list-style-type: none"> <li>• Acupuncture 20 visits/benefit period</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility treatment</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9ZG6SMG01012024>.

- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Routine eye care (Adult) 1 exam/benefit period

**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: New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416, 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](#) 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 518, North Haven, CT 06473-0518

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

New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416

**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.*

## 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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,170</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$40
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</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 (855) 748-1805

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 748-1805 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 (855) 748-1805.

**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) 748-1805:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (855) 748-1805.

**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) 748-1805 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 748-1805 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) 748-1805。

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## Language Access Services:

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ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 748-1805.

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दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 748-1805

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## Language Access Services:

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