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/6REYIND01012023. 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 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,900/person or \$11,800/family for In- <u>Network</u> <u>Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive Care. Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	\$7,450/person or \$14,900/family for In- <u>Network</u> <u>Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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 <u>network</u> provider?	Yes, Pathway X Tiered Hospital. See www.anthem.com or call for a list of network providers. Costs may vary by site of service and how the provider bills.	You pay the least if you use a <u>provider</u> in <u>Preferred Network</u> . You pay more if you use a <u>provider</u> in In-Network. You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> out-of-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral	No.	You can see the specialist you choose without a referral.
to see a specialist?		

A

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

	Services You May Need		What You Will Pay			
Common Medical Event		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	35% coinsurance	Not covered	Virtual visits (Telehealth) benefits available.	
	Specialist visit	Not Applicable	35% coinsurance	Not covered	Virtual visits (Telehealth) benefits available.	
	Preventive care/screening/immunization	Not Applicable	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	35% <u>coinsurance</u>	50% coinsurance	Not covered	none	
·	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	none	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Generic drugs (Tier 1)	Not Applicable	35% <u>coinsurance</u> (retail and home delivery)	Not covered (retail and home delivery)		
	Preferred brand drugs (Tier 2)	Not Applicable	35% <u>coinsurance</u> (retail and home delivery)	Not covered (retail and home delivery)	For more information, refer to "Select Drug List" at	
	Non-preferred brand drugs (Tier 3)	Not Applicable	50% <u>coinsurance</u> (retail and home delivery)	Not covered (retail and home delivery)	http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section	
	Specialty drugs (Tier 4)	Not Applicable	50% <u>coinsurance</u> (retail and home delivery)	Not covered (retail and home delivery)		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	none	
surgery	Physician/surgeon fees	Not Applicable	35% <u>coinsurance</u>	Not covered	none	
If you need immediate	Emergency room care	Not Applicable	50% <u>coinsurance</u>	Covered as In- <u>Network</u>	none	

^{*} For more information about limitations and exceptions, see <u>plan</u> or policy document at https://eoc.anthem.com/eocdps/6REYIND01012023.

	Services You May Need	What You Will Pay				
Common Medical Event		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
medical attention	Emergency medical transportation	Not Applicable	35% coinsurance	Covered as In- <u>Network</u>	Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.	
	Urgent care	Not Applicable	35% coinsurance	Covered as In- <u>Network</u>	none	
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	50% coinsurance	Not covered	100 days/admission for Inpatient rehabilitation and skilled nursing services combined for <u>Preferred Network</u> and In- <u>Network</u> <u>Providers</u> combined.	
	Physician/surgeon fees	Not Applicable	35% <u>coinsurance</u>	Not covered	none	
If you need mental health, behavioral health, or substance	Outpatient services	Not Applicable	Office Visit 35% <u>coinsurance</u> Other Outpatient 35% <u>coinsurance</u>	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatientnone	
abuse services	Inpatient services	35% coinsurance	50% <u>coinsurance</u>	Not covered	none	
	Office visits	Not Applicable	35% coinsurance	Not covered		
If you are	Childbirth/delivery professional services	Not Applicable	35% coinsurance	Not covered	Maternity care may include tests and services described elsewhere	
pregnant	Childbirth/delivery facility services	35% coinsurance	50% coinsurance	Not covered	in the SBC (i.e. ultrasound).	
	Home health care	Not Applicable	35% coinsurance	Not covered	100 visits/benefit period .	
	Rehabilitation services	35% coinsurance	50% coinsurance	Not covered	*See Therapy Services section.	
	Habilitation services	35% coinsurance	50% <u>coinsurance</u>	Not covered	See Therapy Services section.	
If you need help recovering or have other special health needs	Skilled nursing care	35% <u>coinsurance</u>	50% <u>coinsurance</u>	Not covered	100 days/admission for Inpatient rehabilitation and skilled nursing services combined for <u>Preferred</u> Network and In-Network Providers combined.	
	Durable medical equipment	Not Applicable	35% coinsurance	Not covered	*See <u>Durable Medical</u> <u>Equipment</u> Section	
	Hospice services	Not Applicable	35% <u>coinsurance</u>	Not covered	none	
If your child	Children's eye exam	Not Applicable	No charge	Not covered	*See Vision Services section	

^{*} For more information about limitations and exceptions, see $\underline{\textbf{plan}}$ or policy document at $\underline{\text{https://eoc.anthem.com/eocdps/6REYIND01012023}}$.

Common Medical Event			What You Will Pay		
	Services You May Need	Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
needs dental or	Children's glasses	Not Applicable	No charge	Not covered	
eye care	Children's dental check-up	Not Applicable	0% coinsurance	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Infertility treatment
- Routine eve care (Adult)

- Acupuncture
- Dental care (Adult)
- Long-term care
- Routine foot care unless <u>medically</u> <u>necessary</u>

- Bariatric surgery
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Chiropractic care 30 visits/benefit period
- Private-duty nursing 16 hours/benefit period in a Home Setting only

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: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945, 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 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

^{*} For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/6REYIND01012023.

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? Not Applicable

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 <u>plan</u> might cover costs for a sample medical situation, see the next section.

^{*} For more information about limitations and exceptions, see <u>plan</u> or policy document at https://eoc.anthem.com/eocdps/6REYIND01012023.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

O						
Peg is Having a Baby (9 months of in-network pre-natal c hospital delivery)	are and a	Managing Joe's Type 2 Diabe (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)		
 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance Other coinsurance 35% 35% 		 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance Other coinsurance 	\$5,900 35% 35% 35%	 The plan's overall deductible Specialist coinsurance Hospital (facility) coinsurance Other coinsurance 	\$5,900 35% 35% 35%	
This EXAMPLE event includes servilike: Specialist office visits (prenatal care) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood in Specialist visit (anesthesia)	ces	This EXAMPLE event includes servelike: Primary care physician office visits (in disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose medical)	acluding	This EXAMPLE event includes ser like: Emergency room care (including medic Diagnostic test (x-ray) Durable medical equipment (crutches Rehabilitation services (physical therap)	sal supplies)	
Total Example Cost \$12,700		Total Example Cost	\$5,600	Total Example Cost	\$2,800	
In this example, Peg would pay: Cost Sharing		In this example, Joe would pay: Cost Sharing		In this example, Mia would pay: Cost Sharing		
Deductibles Deductibles	\$5,900	Deductibles Deductibles	\$5,400	Deductibles	\$2,800	
Copayments	\$0	<u>Copayments</u>	\$0	Copayments	\$0	
Coinsurance	\$1,600	Coinsurance	\$0	Coinsurance	\$0	
What isn't covered		What isn't covered		What isn't covered		
Limits or exclusions	Limits or exclusions \$60		\$20	Limits or exclusions	\$0	
The total Peg would pay is	\$7,510	The total Joe would pay is	\$5,420	The total Mia would pay is	\$2,800	

(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

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

Armenian (**hայերեն**). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ ։

Bassa (Băsóò Wùdù): M̀ dyi dyi-diè-dè bě bédé bá céè-dè nìà kɛ dyí ní, ɔ mò nì dyí-bèdèìn-dè bé m̀ ké gbo-kpá-kpá kè bỗ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyò dò gbo wùdù kɛ, dá .

Bengali (বাংলা): যদি এই লখিপত্রের বিষয়ে আপলার কোলো প্রশ্ন খাকে, তাহলে আপলার ভাষায় বিলামূল্য সাহাষ্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপলার আছে। একজন দোভাষীর সাথে কথা ব্লার জন্য –তে কল করুল।

Burmese **(မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု သို့ ခေါ် ဆိုပါ။

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。

Dinka (Dinka): Na non thiëëc në ke de ya thorë, ke yin non lon bë yi kuony ku wer alëu bë geer yic yin ne thon du ke cin weu taauë ke piny. Te kor yin ba jam wenë ran ye thok geryic, ke yin col.

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 .

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینهای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 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 .

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 .

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 .

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ય વગર આપની ભાષામાં મદદ અને માહતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો.

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 .

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

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 .

Igbo (Igbo): O bụr ụ na ị nwere ajujụ o bụla gbasara akwukwo a, ị nwere ikike inweta enyemaka na ozi n'asusu gi na akwughi ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo .

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 .

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 .

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

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、 にお電話ください。

Khmer (ខ្មែរ)៖ បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ ។

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

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

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ .

Navajo (**Diné**): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehji bee nił hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'i' hadeesdzih nínízingo koji hodíílnih .

Nepali (नेपाली): यदि यो कागजातबारे तपाईँसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईँसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस्

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff aa.

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 .

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 .

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ: 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.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел.

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 .

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 .

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 .

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 .

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร เพื่อพูดคยกับล่าม

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:

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צו רעדן צו (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 (Yiddish) אן איבערזעצער, רופט

Yoruba (Yorubá): Tí o bá ní eyíkéylí ibere nípa akosíle ylí, o ní etó láti gba iranwó ati iwífún ní ede re lófee. Bá wa ogbufo kan soro, pe

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