# Your summary of benefits

Anthem® BlueCross and BlueShield

Your Contract Code: 4HRD

Your Plan: Anthem Gold Choice PPO 1000/20%/7350

Your Network: Choice PPO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Overall Deductible**<br>*See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.* | $1,000 person / $3,000 family | $3,000 person / $6,000 family | $6,000 person / $12,000 family |
| **Out-of-Pocket Limit**<br>*When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.* | $7,350 person / $14,700 family | $7,350 person / $14,700 family | $14,700 person / $29,400 family |
| **Preventive care/screening/immunization**<br>*Preferred Network and In-Network preventive care is not subject to deductible, if your plan has a deductible.* | No charge | No charge | 50% coinsurance after deductible is met |
| **Doctor Home and Office Services** | | | |
| **Primary Care Visit to treat an injury or illness** | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| **Specialist Care Visit** | $40 copay per visit deductible does not apply | $60 copay per visit deductible does not apply | 50% coinsurance after deductible is met |

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|---|---|---|---|
| **Prenatal and Post-natal Care**<br>*Preferred Network and In-Network preventive prenatal and postnatal services are covered at 100%.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Other Practitioner Visits:** | | | |
| Retail Health Clinic | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Preferred On-line Visit<br>*Includes Mental/Behavioral Health and Substance Abuse*<br>*Live Health Online is the preferred telehealth solution.*<br>*(www.livehealthonline.com).* | No charge for the first 12 visits and then $10 copay per visit deductible does not apply | No charge for the first 12 visits and then $10 copay per visit deductible does not apply | Not covered |
| Other Participating Provider On-line Visit<br>*Includes Mental/Behavioral Health and Substance Abuse* | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Spinal Manipulation<br>*Coverage is limited to 50 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Acupuncture | Not covered | Not covered | Not covered |
| **Other Services in an Office:** | | | |
| Allergy Testing | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Chemo/Radiation Therapy | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Hemodialysis | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |

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|---|---|---|---|
| Prescription Drugs<br>*For the drugs itself dispensed in the office through infusion/injection.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services** | | | |
| **Lab:** | | | |
| Office<br>*Office Cost Share applies only when Freestanding/Reference Labs are not used.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | No charge | No charge | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **X-Ray:** | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | $250 copay per visit deductible does not apply | $250 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):** | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | | |
| **Urgent Care (Office Setting)** | $40 copay per visit deductible does not apply | $60 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| **Emergency Room Facility Services** *Emergency Room copay is waived if directly admitted to the hospital.* | $500 copay per visit and 20% coinsurance deductible does not apply | $500 copay per visit and 20% coinsurance deductible does not apply | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | Covered as In-Network |
| **Emergency Room Mental/Behavioral Health and Substance Abuse Doctor Services** | 20% coinsurance deductible does not apply | 20% coinsurance deductible does not apply | Covered as In-Network |
| **Ambulance (Air and Ground)** | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental/Behavioral Health and Substance Abuse** | | | |
| **Doctor Office Visit** | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| **Facility visit:** | | | |
| Facility Fees | 20% coinsurance deductible does not apply | 40% coinsurance deductible does not apply | 50% coinsurance after deductible is met |
| Doctor Services | 20% coinsurance deductible does not apply | 40% coinsurance deductible does not apply | 50% coinsurance after deductible is met |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Outpatient Surgery** | | | |
| **Facility Fees:** | | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Surgical Center | $250 copay per visit deductible does not apply | $250 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| **Doctor and Other Services:** | | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Surgical Center | No charge | No charge | 50% coinsurance after deductible is met |
| **Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)** | | | |
| **Facility fees (for example, room & board)** *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Doctor and other services** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Recovery & Rehabilitation** | | | |
| **Home Health Care** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Rehabilitation services (for example, physical/speech/occupational therapy):** | | | |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| Office<br>*Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Outpatient Hospital<br>*Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Habilitation services (for example, physical/speech/occupational therapy):** | | | |
| Office<br>*Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | $20 copay per visit deductible does not apply | $40 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| Outpatient Hospital<br>*Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings. Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Cardiac rehabilitation**<br>Office | $40 copay per visit deductible does not apply | $60 copay per visit deductible does not apply | 50% coinsurance after deductible is met |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Skilled Nursing Care (in a facility)** *Coverage is limited to 150 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Hospice** | 0% coinsurance after deductible is met | 0% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Durable Medical Equipment** | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prosthetic Devices** *Coverage for hearing aids services is limited to 1 item per ear every 3 years. Limit is combined Preferred Network, In-Network and Non-Network across all settings.* | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |

# Your summary of benefits

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Pharmacy Deductible** | Not applicable | Not applicable | Not applicable |
| **Pharmacy Out of Pocket** | Combined with In-Network medical out of pocket maximum | Combined with In-Network medical out of pocket maximum | Combined with Non-Network medical out of pocket maximum |
| **Prescription Drug Coverage**<br>*Select Drug List*<br>*This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.* | | | |
| **Tier 1a - Typically Lower Cost Generic**<br>*Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.* | $5 copay per prescription, deductible does not apply (retail) and $13 copay per prescription, deductible does not apply (home delivery) | $15 copay per prescription, deductible does not apply (retail) and Not covered (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 1b - Typically Generic**<br>*Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.* | $20 copay per prescription, deductible does not apply (retail) and $50 copay per prescription, deductible does not apply (home delivery) | $30 copay per prescription, deductible does not apply (retail) and Not covered (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 2 – Typically Preferred Brand**<br>*Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.* | $35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery) | $45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |

# Your summary of benefits

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Tier 3 - Typically Non-Preferred Brand**<br>*Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.* | $70 copay per prescription, deductible does not apply (retail) and $210 copay per prescription, deductible does not apply (home delivery) | $80 copay per prescription, deductible does not apply (retail) and Not covered (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)**<br>*Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.* | 25% coinsurance up to $500 per prescription, deductible does not apply (retail and home delivery) | 25% coinsurance up to $600 per prescription, deductible does not apply (retail) and Not covered (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |

# Your summary of benefits

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| *This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.*<br>*Only children's vision services count towards your out of pocket limit.* | | |
| **Children's Vision Essential Health Benefits (up to age 19)** | | |
| **Child Vision Deductible** | Not Applicable | Not Applicable |
| **Vision exam**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $30 |
| **Frames**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $45 |
| **Single Vision Lenses**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $25 |
| **Bifocal Vision Lenses**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $40 |
| **Trifocal Vision Lenses**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $55 |
| **Elective contact lenses**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $60 |
| **Non-Elective Contact Lenses**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.* | No charge | Reimbursed Up to $210 |
| **Adult Vision (age 19 and older)** | | |
| **Adult Vision Deductible** | Not Applicable | Not Applicable |

# Your summary of benefits

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Vision exam**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.* | $20 copay | Reimbursed Up to $30 |
| **Frames** | Not covered | Not covered |
| **Single Vision Lenses** | Not covered | Not covered |
| **Bifocal Vision Lenses** | Not covered | Not covered |
| **Trifocal Vision Lenses** | Not covered | Not covered |
| **Elective contact lenses** | Not covered | Not covered |
| **Non-Elective Contact Lenses** | Not covered | Not covered |

# Your summary of benefits

| Covered Dental Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| *This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.*<br>*Only children's dental services count towards your out of pocket limit.* | | |
| **Children's Dental Essential Health Benefits**<br>**Diagnostic and preventive**<br>*Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.* | No charge | 30% coinsurance deductible does not apply |
| **Basic services** | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Major services** | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Medically Necessary Orthodontia services** | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Cosmetic Orthodontia services** | Not covered | Not covered |
| **Deductible** | Combined with medical deductible | Combined with medical deductible |
| **Adult Dental** | | |
| **Diagnostic and preventive** | Not covered | Not covered |
| **Basic services** | Not covered | Not covered |
| **Major services** | Not covered | Not covered |
| **Deductible** | Not covered | Not covered |
| **Annual maximum** | Not covered | Not covered |

# Your summary of benefits

**Notes:**

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating providers charge.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- If your plan includes out-of-network coverage, covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. Except for out-of-network emergency services from a professional or facility inside Nevada, when receiving care from providers out-of-network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out-of-network out-of-pocket limit.
- Vision services are not subject to the annual deductible.
- Emergency Care you receive from an Out-of-Network Provider will be covered as an In-Network service. But, you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- All covered services cost shares for both Preferred Providers and In-Network Providers apply to the In-Network out-of-pocket maximum.

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## Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 330-1218

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

**(TTY/TDD: 711)**

**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) 330-1218 .

**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) 330-1218:

**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) 330-1218。

**Farsi** (فارسي) : 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 (855) 330-1218 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 (855) 330-1218.

**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 (855) 330-1218.

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**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1218로 문의하십시오.

## Language Access Services:

**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 330-1218.

**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: (855) 330-1218.

**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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1218 ਤੇ ਕਾਲ ਕਰੋ।

**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. (855) 330-1218.

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