

Anthem Blue Cross

Custom Classic PPO 500/35/20 (National Formulary Rx \$5/\$20/\$30/\$50/30%)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual + Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.anthem.com/eocdps/ca/fi> or by calling (855) 333-5730.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 single / \$1,000 family for In-Network Providers. Does not apply to Primary Care visit, Preventive care, Prescription Drugs, and Specialist visit. \$500 single / \$1,000 family for Out-of-Network Providers.	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; \$3,000 single / \$6,000 family for In-Network Providers. \$10,000 single / \$20,000 family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Copayments for certain services, Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes, Prudent Buyer PPO. For a list of In-Network providers, see	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an

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CA/L/F/PPO/LP2015/WLK7Y/LR2055/01-17

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why this Matters:
	www.anthem.com/ca or call (855) 333-5730 .	out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 3 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No; you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay per visit deductible does not apply	40% coinsurance after deductible is met	-----none-----
	Specialist visit	\$35 copay per visit deductible does not apply	40% coinsurance after deductible is met	-----none-----
	Other practitioner office visit	Chiropractor \$35 copay per visit deductible does not apply Acupuncture \$35 copay per visit deductible does not apply	Chiropractor 40% coinsurance after deductible is met Acupuncture 40% coinsurance after deductible is met	Chiropractor Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 visits per benefit period. Deductible does not apply to In-Network providers. Acupuncture Coverage for In-Network Providers and Non-Network Providers combined is limited to 20 visits per benefit period. Deductible does not apply to In-Network providers.
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible is met	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance after deductible is met X-Ray – Office 20% coinsurance after	Lab – Office 40% coinsurance after deductible is met X-Ray – Office 40% coinsurance after	Lab – Office -----none----- X-Ray – Office -----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		deductible is met	deductible is met	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Coverage for Out-of-Network Providers is limited to \$800 maximum per test.
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/</p> <p>National</p>	Tier1a - Typically Lower Cost Generic	\$5 copay (retail only) after deductible is met and \$12.50 copay (home delivery only) after deductible is met	50% coinsurance (retail only) after deductible is met	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.
	Tier1b - Typically Generic	\$20 copay (retail only) after deductible is met and \$50 copay (home delivery only) after deductible is met	50% coinsurance (retail only) after deductible is met	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.
	Tier2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$30 copay (retail only) after deductible is met and \$90 copay (home delivery only) after deductible is met	50% coinsurance (retail only) after deductible is met	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.
	Tier3 - Typically Non-Preferred Brand and Generic Drugs	\$50 copay (retail only) after deductible is met and \$150 copay (home delivery only) after deductible is met	50% coinsurance (retail only) after deductible is met	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.
	Tier4 - Typically Preferred Specialty	30% coinsurance up to	50% coinsurance (retail	Covers up to a 30 day supply (retail

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
	(brand and generic)	a \$250 maximum per prescription (retail and home delivery) after deductible is met	only) after deductible is met	pharmacy and home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Coverage for Out-of-Network Providers is limited to \$350 maximum per visit.
	Physician/surgeon fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-----none-----
If you need immediate medical attention	Emergency room services	\$100 copay per admission and then 20% coinsurance after deductible is met	Covered as In-Network	Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	20% coinsurance after deductible is met	Covered as In-Network	-----none-----
	Urgent care	\$35 copay per visit deductible does not apply	40% coinsurance after deductible is met	Costs may vary by site of service. Deductible does not apply to In-Network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Co-pay \$500 if you do not receive preauthorization. Coverage is limited to \$1,000 maximum per day. Apply to Out-of-Network Providers. Apply to non-emergency admission.
	Physician/surgeon fee	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit \$35 copay per visit deductible does not apply Other Outpatient 20% coinsurance after deductible is met	Office Visit 40% coinsurance after deductible is met Other Outpatient 40% coinsurance after deductible is met	Office Visit Deductible does not apply to In-Network providers. Other Outpatient -----none-----
	Mental/Behavioral health inpatient services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Co-pay \$500 if you do not receive preauthorization. Coverage is limited to \$1,000 maximum per day. Apply to Out-of-Network Providers. Apply to non-emergency admission.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Office Visit \$30 copay per visit deductible does not apply Other Outpatient 20% coinsurance after deductible is met	Office Visit 40% coinsurance after deductible is met Other Outpatient 40% coinsurance after deductible is met	Office Visit Deductible does not apply to In-Network providers. Other Outpatient -----none-----
	Substance use disorder inpatient services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Co-pay \$500 if you do not receive preauthorization. Coverage is limited to \$1,000 maximum per day. Apply to Out-of-Network Providers. Apply to non-emergency admission.
If you are pregnant	Prenatal and postnatal care	\$30 copay per visit after deductible is met	40% coinsurance after deductible is met	Deductible does not apply to In-Network providers.
	Delivery and all inpatient services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Co-pay \$500 if you do not receive preauthorization. Coverage is limited to \$1,000 maximum per day. Apply to Out-of-Network Providers. Apply to non-emergency admission.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Costs may vary by site of service.
	Habilitation services	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-----none-----
	Skilled nursing care	20% coinsurance after deductible is met	40% coinsurance after deductible is met	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 day limit per benefit period.
	Durable medical equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met	-----none-----
	Hospice service	No charge	40% coinsurance after deductible is met	-----none-----
If your child	Eye exam	Not covered	Not covered	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
needs dental or eye care	Glasses	Not covered	Not covered	-----none-----
	Dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 333-5730. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

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

Department of Managed Health Care
California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

California Department of Managed
Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
<http://www.healthhelp.ca.gov>
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'niilígú bí'kéhgo bich'í hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,930
- Patient pays \$1,610

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$50
Coinsurance	\$910
Limits or exclusions	\$150
Total	\$1,610

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,923
- Patient pays \$477

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$137
Copays	\$300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$477

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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) 333-5730

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5730 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) 333-5730.

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) 333-5730:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà ke dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀in-dɛ̀ bɛ̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídì-wùdùùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (855) 333-5730.

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) 333-5730 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5730 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) 333-5730。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 333-5730.

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 (855) 333-5730.

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 (855) 333-5730 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) 333-5730.

Language Access Services:

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 (855) 333-5730.

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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 (855) 333-5730.

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) 333-5730.

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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 (855) 333-5730.

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Language Access Services:

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Language Access Services:

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(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (855) 333-5730.

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