

# Anthem Blue Cross City of Riverside Custom Premier HMO 15

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: HMO



**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 <b>deductible</b> ?	\$0	See the chart starting on page 3 for your costs for services this plan covers.
Are there other <b>deductibles</b> for specific services?	Yes; <b>\$150</b> per member / <b>\$450</b> family for Prescription Drug.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes; <b>\$1,500</b> individual / <b>\$3,000</b> family for In-Network Providers.	The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?	Infertility services copay, Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <b>network of providers</b> ?	Yes, California Care HMO. For a list of In-Network providers, see <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this plan pays different kinds of <b>providers</b> .

**Questions:** Call (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/L/F/CITYOFRIVERSIDECUSTOM PREMIER HMO 15-HMO/NA/NA/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](http://www.cciio.cms.gov) or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why this Matters:
<b>Do I need a referral to see a <u>specialist</u>?</b>	Yes; you need written approval to see a specialist. There may be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
<b>Are there services this plan doesn't cover?</b>	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 <b><u>excluded services</u></b> .



- **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 Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay per visit	Not covered	-----none-----
	Specialist visit	\$15 copay per visit	Not covered	-----none-----
	Other practitioner office visit	Chiropractor No cost share \$10 copay per visit (Self-referred) Acupuncture \$15 copay per visit	Chiropractor Not covered Acupuncture Not covered	Chiropractor Coverage for In-Network Providers is limited to 60-days limit period of care for physical, occupational, or speech therapy or chiropractic care. Self-referred chiropractor An additional 30 self-referred chiropractic visits.
	Preventive care/ screening/immunization	No cost share	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office No cost share	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	\$100 copay per test	Not covered	Costs may vary by site of service.
If you need drugs to treat your	Tier 1 - Typically Generic	\$15 copay per prescription (retail only)	\$15 copay per prescription (retail)	Covers up to a 30 day supply (retail pharmacy) Covers up to a

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
<p><b>illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a></p>		and \$37.50 copay per prescription (home delivery only)	only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	90 day supply (home delivery program) Prescription Drug deductible does not apply. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.
	Tier 2 - Typically Preferred / Brand	\$30 copay per prescription (retail only) and \$90 copay per prescription (home delivery only)	\$30 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	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 on all tiers for retail fills that exceed 30 days. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				applicable copay for the dispensed drug will apply.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$50 copay per prescription (retail only) and \$150 copay per prescription (home delivery only)	\$50 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	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 on all tiers for retail fills that exceed 30 days. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
	Tier 4 - Typically Specialty Drugs	30% coinsurance up to \$250 per prescription (retail only) and 30% coinsurance up to \$250 per prescription (home	\$30 copay per prescription (retail only) plus 50% of the remaining prescription drug	Covers up to a 30 day supply for specialty pharmacy. Classified specialty drugs must be obtained through our specialty pharmacy program and are subject to the

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
		delivery only)	maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	terms of the program.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No cost share	Not covered	-----none-----
	Physician/surgeon fees	No cost share	Not covered	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$100 copay per visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	No cost share	Covered as In-Network	-----none-----
	Urgent care	\$15 copay per visit	Covered as In-Network	Copay waived if admitted inpatient or outpatient ER.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No cost share	Not covered	-----none-----
	Physician/surgeon fee	No cost share	Not covered	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$15 copay per visit for non-preventive visits Mental/Behavioral Health Other Outpatient Items and Services No cost share	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Other Outpatient Items and Services Not covered	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Other Outpatient Items and Services -----none-----
	Mental/Behavioral health inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder	Substance Use Office	Substance Use	Substance Use Office Visit

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	outpatient services	Visit \$15 copay per visit for non-preventive visits Substance Use Facility Visit - Facility Charges No cost share	Office Visit Not covered Substance Use Facility Visit - Facility Charges Not covered	-----none----- Substance Use Facility Visit - Facility Charges -----none-----
	Substance use disorder inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$15 copay per visit	Not covered	-----none-----
	Delivery and all inpatient services	No cost share	Not covered	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	\$15 copay per visit	Not covered	Coverage is limited to 100 visits per benefit period. One visit by a home health aide equals four hours or less.
	Rehabilitation services	No cost share	Not covered	Coverage is limited to 60-days limit period of care for physical, occupational, speech therapy or chiropractic care.
	Habilitation services	No cost share	Not covered	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	No cost share	Not covered	Coverage is limited to 100 days limit per benefit period.
	Durable medical equipment	No cost share	Not covered	-----none-----
	Hospice service	No cost share	Not covered	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	-----none-----
	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)
- Infertility treatment
- Long- term care
- Non-emergency care when traveling outside the U.S.
- 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 for morbid obesity only.
- Chiropractic care
- Hearing aids Coverage is limited to one hearing aid per ear every three years.

## 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](http://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](http://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](http://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](mailto: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 íinízinigo t'áa diné k'éjígoo, t'áa shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa'íini'taago eíya, t'áa shoodí diné ya atáh halne'ígúí ní béesh bee hane'í wólta' bí'ki si'niilígúí 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.

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*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 \$7,250
- Patient pays \$290

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$140
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$290</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,570
- Patient pays \$830

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$750
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$830</b>

# 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**, **co payments**, 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.

**Questions:** Call (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

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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 nià ke dyí ní, ɔ̀ m̀ò nì dyí-bédéìn-dɛ̀ b́é m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ d́é m̀ bídǐ-wùdùùn b́ó pídyi. B́é m̀ ké wuɖu-zììn-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 n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te k̄ɔr yin ba jam wēnē ran ye thok geryic, ke yin c̄ɔl (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.

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**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:

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**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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**Igbo (Igbo):** O bụrụ na ị nwere ajujụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5730.

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## Language Access Services:

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**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 333-5730.

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກ່ຽວກັບລາຍລະອຽດ, ໃຫ້ໂທຫາ (855) 333-5730.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjì bee nił hodoonih t'áadoo báąh ilinígóó.  
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojì' hodiilnih (855) 333-5730.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 333-5730

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 333-5730 bilbilla.

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## Language Access Services:

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