




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/ca/5SRVSMG01012021>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 383-7248 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,500/person or \$3,000/family for In- <a href="#">Network Providers</a> . \$3,000/person or \$6,000/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care <a href="#">Specialist Visit Preventive Care</a> for In- <a href="#">Network Providers</a> . Vision for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$250/person or \$500/family for <a href="#">Prescription Drugs</a> for <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> combined. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,500/person or \$15,000/family for In- <a href="#">Network Providers</a> . \$15,000/person or \$30,000/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, Select PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 383-7248 for a list of	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your

	<a href="#">network providers.</a>	<a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not Applicable	\$5/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	Not Applicable	\$65/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	Not Applicable	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office \$15/visit, <a href="#">deductible</a> does not apply X-Ray – Office \$15/service, <a href="#">deductible</a> does not apply	Lab – Office 50% <a href="#">coinsurance</a> X-Ray – Office 50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	\$100/service then 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$380 maximum/admission for Non- <a href="#">Network Providers</a> .
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is	Tier 1 - Typically Generic	\$5/prescription, Prescription Drug <a href="#">deductible</a> does not apply (retail) and \$13/prescription, Prescription Drug <a href="#">deductible</a> does not	\$15/prescription, Prescription Drug <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SRVSMG01012021>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>		apply (home delivery)			
Select Drug List	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$50/prescription, Prescription Drug <a href="#">deductible</a> applies (retail) and \$150/prescription, Prescription Drug <a href="#">deductible</a> applies (home delivery)	\$75/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$100/prescription, Prescription Drug <a href="#">deductible</a> applies (retail) and \$300/prescription, Prescription Drug <a href="#">deductible</a> applies (home delivery)	\$110/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	30% <a href="#">coinsurance</a> up to \$250/prescription, Prescription Drug <a href="#">deductible</a> applies (retail and home delivery)	40% <a href="#">coinsurance</a> up to \$250/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Costs may vary by site of service.\$380 maximum/admission for Non- <a href="#">Network Providers</a> .
	Physician/surgeon fees	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not Applicable	\$250/visit then 30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	Copay waived if admitted. 30% <a href="#">coinsurance</a> for Emergency Room Physician Fee In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> .

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SRVSMG01012021>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	Not Applicable	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	Not Applicable	\$65/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$650 maximum/day for Non- <a href="#">Network Providers</a> . 100 days/benefit period for Inpatient rehabilitation for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> combined.
	Physician/surgeon fees	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Office Visit \$5/visit <a href="#">deductible</a> does not apply Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$650 maximum/day for Non- <a href="#">Network Providers</a> . 30% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . 50% <a href="#">coinsurance</a> for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .
If you are pregnant	Office visits	Not Applicable	No charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . \$5/visit <a href="#">deductible</a> does not apply for Postnatal <a href="#">Preferred Network Providers</a> . Not covered for Postnatal In- <a href="#">Network Providers</a> . 50% <a href="#">coinsurance</a> for Postnatal Non- <a href="#">Network Providers</a> . In- <a href="#">Network</a> preventative prenatal and postnatal services are
	Childbirth/delivery professional services	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SRVSMG01012021>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
					covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$75 maximum/visit for Non- <a href="#">Network Providers</a> . 100 visits/year for Home Health and Private Duty Nursing combined for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	Not Applicable	\$5/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	Not Applicable	\$5/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	Not Applicable	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$150 maximum/day for Non- <a href="#">Network Providers</a> . 100 days/benefit period for skilled nursing services for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	Not Applicable	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	Not Applicable	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	\$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a>	*See Vision Services section
	Children's glasses	Not Applicable	No charge	\$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a>	
	Children's dental check-up	Not Applicable	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	*See Dental Services section

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SRVSMG01012021>.

## Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Dental care (Adult)
- Long-term care
- Hearing aids
- Routine foot care unless medically necessary

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

- Acupuncture
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Private-duty nursing 100 visits/year combined with Home Health
- Chiropractic care 20 visits/year
- Routine eye care (Adult) 1 exam/benefit period.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 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) 466-2219, <https://www.dmhca.gov/>

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.gov/>

### 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**.

\* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/ca/5SRVSMG01012021>.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*



## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">copayment</a>	\$15

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$2,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,760</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">copayment</a>	\$15

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">copayment</a>	\$15

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 383-7248

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 383-7248 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) 383-7248.

**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) 383-7248:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédèin-dɛ̀ bɛ̀ m̀ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídí-wùdùùn b́ó pídyi. Bɛ̀ m̀ kɛ̀ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ̀, d́á (855) 383-7248.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 383-7248 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 383-7248 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电(855) 383-7248。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin col (855) 383-7248.

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**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) 383-7248 تماس بگیرید.

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## Language Access Services:

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