### 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](https://eoc.anthem.com/eocdps/ca). 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/](https://www.healthcare.gov/sbc-glossary/) or call (855) 333-5730 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,500/person or $2,800/member or $3,000/family for In-Network Providers, $2,500/person or $2,800/member or $5,000/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, Preventive Care for In-Network Providers.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/person or $3,000/member or $6,000/family for In-Network Providers, $6,000/person or $6,000/member or $12,000/family for Non-Network Providers.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, Prudent Buyer PPO. See <a href="https://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of provider.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan would pay.</td>
</tr>
</tbody>
</table>
Do you need a **referral** to see a **specialist**?

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% <strong>coinsurance</strong></td>
<td>You may have to pay for services that aren't preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</td>
</tr>
</tbody>
</table>

| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% **coinsurance** | 40% **coinsurance** | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 20% **coinsurance** | 40% **coinsurance** | --------none-------- |

**If you need drugs to treat your illness or condition**

More information about **prescription drug coverage** is available at [http://www.anthem.com/ca/pharmacyinformation/](http://www.anthem.com/ca/pharmacyinformation/)

| National Drug List | Generic Drugs | 20% **coinsurance** up to $250/prescription (retail and home delivery) | 40% **coinsurance** up to $250/prescription (retail) and Not covered (home delivery) | --------none-------- |
| | Brand Name Formulary Drugs | 20% **coinsurance** up to $250/prescription (retail and home delivery) | 40% **coinsurance** up to $250/prescription (retail) and Not covered (home delivery) | Most home delivery is 90-day supply. *See Prescription Drug section of the **plan** or policy document (e.g. evidence of coverage or certificate). |
| | Brand Name Non-Formulary Drugs | 20% **coinsurance** up to $250/prescription (retail and home delivery) | 40% **coinsurance** up to $250/prescription (retail) and Not covered (home delivery) | --------none-------- |
| | Specialty Pharmacy Drugs (brand and generic) | 20% **coinsurance** up to $250/prescription (retail and home delivery) | Not Applicable | --------none-------- |

**If you have outpatient surgery**

| Facility fee (e.g., ambulatory surgery center) | 20% **coinsurance** | 40% **coinsurance** | --------none-------- |
| | Physician/surgeon fees | 20% **coinsurance** | 40% **coinsurance** | --------none-------- |

* For more information about limitations and exceptions, see **plan** or policy document at [https://eoc.anthem.com/eocdps/ca/](https://eoc.anthem.com/eocdps/ca/).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>Covered as In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 20% coinsurance</td>
<td>Office Visit 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient 20% coinsurance</td>
<td>Other Outpatient 40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/ft.
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
- Dental Check-up
- Routine eye care (Adult)
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Pediatric)
- Glasses for a child
- Long-term care
- Weight loss programs

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

- Acupuncture 12 visits/benefit period
- Hearing aids one hearing aid/ear every three years.
- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 24 visits/benefit period
- Private-duty nursing in a Home Setting only

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.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.dmhc.ca.gov/

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/fi.
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? 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.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/ca/fi.
### 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 plan's overall deductible**: $2,800
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $70

**The total Peg would pay is**: $4,870

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible**: $2,800
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

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)

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $400

**The total Joe would pay is**: $3,700

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible**: $2,800
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $10

**The total Mia would pay is**: $2,810

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 përthyes, telefononi (855) 333-5730

Amharic (አማርኛ): ከለሽ ከጓሮ ያገኝ ይታይ ይትወል ከሚስ ይትወል ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ ይታይ (855) 333-5730

Arabic: إذا كنت تريد أي استفسارات بشأن هذا المستند، ففيّح لك الحصول على المساعدة والمعلومات بilingual 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:


Bengali (বাংলা): যদি এই পত্রিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসূত্ত সাহায্য পাওয়া ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5730 -তে কল করুন।

Burmese (မြန်မာ): သင်၏အများအားဖြင့်ကြည့်ရှုရန်မှာ အခြားဘာသာဖြင့်ကြည့်ရှုရန်လိုပါသည်။ အကြောင်းကြားစီမံမှုအတွက် (855) 333-5730

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 nang thèéè nè ke de yañ thòre, ke yin nang log bë yi kuony ku wer alek bë geè yie yin ne thóó dü ke cim wëw tàžuè ke piny. Te kor yin ba jam wènè ran yè thok gëryic, ke yin col (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 (فارسی): در صورتی که سوالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک‌ها بدون هیچ هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره ۳۳۳-۵۷۳۰ تماس بگیرید.
Language Access Services:

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.

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.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε τη δυνατότητα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5730.

Gujarati (ગુજરાતી): તમી શિખા કે જાણવા મેળણ કારણે જાણમા છે કે આ દસ્તાવેજ તમારે કોઈ પણ પ્રશ્ન છે, તો તમે તમારી ભાષામાં આ માહ્યત્વની સાધનો માટે મોટી સહાય અને માહિતી મેળવી શકો છો. તમે દર સમયે એક યોગ્ય સમારોહની જરૂર છો, તેને કોલ કરો (855) 333-5730.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn éd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5730.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषियों से बात करने के लिए, कॉल करें (855) 333-5730.

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.

Igbo (Igbo): Ọ bụrụ na ị nwere ajiụgụ ọ bula gbasara akwụkwọ a, ị nwere ịchọ ịmveta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ ọ bula. Ka gi na ọkwa okwu kwuo okwu, kpọọ (855) 333-5730.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (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 (ລາວ): ເຖິງບໍ່ມີການປ່ຽນແປງຄຳແນວຄ່າຄ່າຄ່າຄ່າໜ່ວຍໜ່ວຍ, ສ່ວນບໍ່ມີການເຂົ້າສົ່ມຄ່າຄ່າຄ່າຄ່າໜ່ວຍໜ່ວຍ ແລະ ສ່ວນນີ້ບໍ່ມີການແປງຄ່າຄ່າຄ່າຄ່າໜ່ວຍໜ່ວຍ. 
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Navajo (Diné): Díí naaltsoos biká’ígíí lahgo bina’idilkidgo ná bohonédzá doó bee ahóó’tí’ t’áá ni niiaad k’ehjí bee ni ni hodoonoíii t’áadoo bááh dinígoó. 
Ata’ halne’ígíí la’ bich’í’ hadeesdizh ninízíingo kojí’ hodílníih (855) 333-5730.

Nepali (नेपाली): यदि आप कागजातवारे तपाईंको केही प्रश्नहरू हुन भने, आफ्नो भाषामा निश्चित रुपमा तपाईंको प्रश्न पाउने हुनुहुनुहुनु हुनुहुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हुनु हु
(855) 333-5730

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabdoo tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaama dubeachauff, (855) 333-5730 bilbilla.


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Language Access Services:

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Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 333-5730.

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Yiddish (אידיש) (Yiddish): (855) 333-5730. אנא יصاصו לעניין, רופט

Yoruba (Yorùbá): Ti o bá ní èyíkèyì òbèrè nipa àkòsìlé yìí, o ní ètò làtì gbà èrinwò àti ibiwàà ni èdè rẹ̀ ìfòrí. Bá wà ogbùfù kàn àtòyì, pe (855) 333-5730.
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