



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, coverage, you may access your summary plan description at https://totalrewards.northropgrumman.com/download/file_library/146/NGHPSPD_2024FINAL.PDF.

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/ or call (844) 457-0614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,750/employee or \$3,500/employee + spouse or \$3,500/employee + children or \$3,500/employee + family. For In- Network Providers . \$3,400/ employee or \$5,600/employee + spouse or \$5,600/employee + children or \$6,800/employee + family for Out-of-Network Providers .	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care for In- Network and Out-of-Network Providers and telemedicine visits with Live Health Online.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,000/employee or \$6,000/employee + spouse or \$6,000/employee + children or \$8,000/employee + family for In- Network Providers . \$8,000/employee or \$12,000/employee + spouse or \$12,000/employee + children or \$16,000/employee + family for	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.

	Out-of-Network Providers.	
What is not included in the out-of-pocket limit?	Services deemed not medically necessary by Medical Management and/or Anthem, Premiums , balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	See anthem.com/ca or call (844) 457-0614 for a list of network providers .	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 pays (balance billing). Be aware your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Coinsurance applies to both in-person and virtual visits with your provider . Applicable cost shares apply to Live Health Online Visits.
	Specialist visit	20% coinsurance	50% coinsurance	-----none-----
	Preventive care / screening /immunization	No charge, deductible does not apply	No charge, deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required for MRI, MRA and PET Scans. Please check with your plan for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic Drugs	20% coinsurance (retail) and 20% coinsurance up to a \$200 maximum/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible .
	Formulary Brand Name Drugs	25% coinsurance (retail) and 25% coinsurance up to a \$200 maximum/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible .
	Non- Formulary Brand Name Drugs	35% coinsurance (retail) and 35% coinsurance up to a \$200 maximum/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible .
	Specialty drugs	25% coinsurance up to a \$400 maximum /prescription	Not covered	Medical deductible applies. Check with plan for details.
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In- Network	20% coinsurance for Emergency Room Physician Fee. Failure to obtain preauthorization for Emergency admission (require notification no later than 72 business hours after admission) may result in non-coverage.
	Emergency medical transportation	20% coinsurance	Covered as In- Network	Failure to obtain preauthorization for air ambulance may result in non-coverage
	Urgent care	20% coinsurance	50% coinsurance	\$10 copayment applies to Live Health Online Visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit Coinsurance applies to both in-person and virtual visits with your provider. Applicable cost shares apply to Live Health Online Visits. Other Outpatient Preauthorization is required for daycare, partial hospitalization, and intensive outpatient care.
	Inpatient services	20% coinsurance	50% coinsurance	20% coinsurance for Inpatient Physician Fee In- Network Providers . 50% coinsurance for Inpatient Physician Fee Out-of-Network Providers . Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required for inpatient stay that exceeds 48 hours of normal delivery and 96 hours after a cesarean delivery.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	100 visits/benefit period including private-duty nursing in and out of network combined. Preauthorization is required.
	Rehabilitation services	20% coinsurance	50% coinsurance	-----none-----
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	100 visits/benefit period in and out of network combined. Preauthorization is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Includes two hearing aids/benefit year. Wigs and toupees are limited to \$1,500/benefit year. One pair of custom shoes or custom molded inserts prescribed by a physician per benefit year. Preauthorization is required for all rentals and purchases over \$1,500.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-coverage. Bereavement is excluded.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

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 care (adult) | • Dental Check-up |
| • Long- term care | • Routine eye care (adult) | • Routine foot care unless you have been diagnosed with diabetes. |
| • Weight loss programs | | |

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

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|--|---|---------------------|
| • Abortion | • Acupuncture 12 visits/benefit period. | • Bariatric surgery |
| • Chiropractic care 24 visits/benefit period. | • Hearing aids two/benefit period. | |
| • Most coverage provided outside the United States. See www.bcbsglobalcore.com | • Private-duty nursing only covered in the home. 100 visits/benefit period including home health care . | |

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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. 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](#), PO Box 54159, Los Angeles, CA 90054-0159

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

Does this [plan](#) provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 [plan](#) 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 plan's overall deductible	\$1,750
■ 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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$2,216
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,026

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,750
■ 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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$1,141
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,946

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

■ The plan's overall deductible	\$1,750
■ 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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$62
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,812

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 (844) 457-0614

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 457-0614 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 (844) 457-0614.

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՝ (844) 457-0614

Bassa (𞀀𞀃𞀆𞀇𞀈𞀉𞀊𞀋𞀌𞀍𞀎𞀏𞀐𞀑𞀒𞀓𞀔𞀕𞀖𞀗𞀘𞀙𞀚𞀛𞀜𞀝𞀞𞀟𞀠𞀡𞀢𞀣𞀤𞀥𞀦𞀧𞀨𞀩𞀪𞀫𞀬𞀭𞀮𞀯𞀰𞀱𞀲𞀳𞀴𞀵𞀶𞀷𞀸𞀹𞀺𞀻𞀼𞀽𞀾𞀿𞁀𞁁𞁂𞁃𞁄𞁅𞁆𞁇𞁈𞁉𞁊𞁋𞁌𞁍𞁎𞁏𞁐𞁑𞁒𞁓𞁔𞁕𞁖𞁗𞁘𞁙𞁚𞁛𞁜𞁝𞁞𞁟𞁠𞁡𞁢𞁣𞁤𞁥𞁦𞁧𞁨𞁩𞁪𞁫𞁬𞁭𞁮𞁯𞁰𞁱𞁲𞁳𞁴𞁵𞁶𞁷𞁸𞁹𞁺𞁻𞁼𞁽𞁾𞁿𞂀𞂁𞂂𞂃𞂄𞂅𞂆𞂇𞂈𞂉𞂊𞂋𞂌𞂍𞂎𞂏𞂐𞂑𞂒𞂓𞂔𞂕𞂖𞂗𞂘𞂙𞂚𞂛𞂜𞂝𞂞𞂟𞂠𞂡𞂢𞂣𞂤𞂥𞂦𞂧𞂨𞂩𞂪𞂫𞂬𞂭𞂮𞂯𞂰𞂱𞂲𞂳𞂴𞂵𞂶𞂷𞂸𞂹𞂺𞂻𞂼𞂽𞂾𞂿𞃀𞃁𞃂𞃃𞃄𞃅𞃆𞃇𞃈𞃉𞃊𞃋𞃌𞃍𞃎𞃏𞃐𞃑𞃒𞃓𞃔𞃕𞃖𞃗𞃘𞃙𞃚𞃛𞃜𞃝𞃞𞃟𞃠𞃡𞃢𞃣𞃤𞃥𞃦𞃧𞃨𞃩𞃪𞃫𞃬𞃭𞃮𞃯𞃰𞃱𞃲𞃳𞃴𞃵𞃶𞃷𞃸𞃹𞃺𞃻𞃼𞃽𞃾𞃿𞄀𞄁𞄂𞄃𞄄𞄅𞄆𞄇𞄈𞄉𞄊𞄋𞄌𞄍𞄎𞄏𞄐𞄑𞄒𞄓𞄔𞄕𞄖𞄗𞄘𞄙𞄚𞄛𞄜𞄝𞄞𞄟𞄠𞄡𞄢𞄣𞄤𞄥𞄦𞄧𞄨𞄩𞄪𞄫𞄬𞄭𞄮𞄯𞄰𞄱𞄲𞄳𞄴𞄵𞄶𞄷𞄸𞄹𞄺𞄻𞄼𞄽𞄾𞄿𞅀𞅁𞅂𞅃𞅄𞅅𞅆𞅇𞅈𞅉𞅊𞅋𞅌𞅍𞅎𞅏𞅐𞅑𞅒𞅓𞅔𞅕𞅖𞅗𞅘𞅙𞅚𞅛𞅜𞅝𞅞𞅟𞅠𞅡𞅢𞅣𞅤𞅥𞅦𞅧𞅨𞅩𞅪𞅫𞅬𞅭𞅮𞅯𞅰𞅱𞅲𞅳𞅴𞅵𞅶𞅷𞅸𞅹𞅺𞅻𞅼𞅽𞅾𞅿𞆀𞆁𞆂𞆃𞆄𞆅𞆆𞆇𞆈𞆉𞆊𞆋𞆌𞆍𞆎𞆏𞆐𞆑𞆒𞆓𞆔𞆕𞆖𞆗𞆘𞆙𞆚𞆛𞆜𞆝𞆞𞆟𞆠𞆡𞆢𞆣𞆤𞆥𞆦𞆧𞆨𞆩𞆪𞆫𞆬𞆭𞆮𞆯𞆰𞆱𞆲𞆳𞆴𞆵𞆶𞆷𞆸𞆹𞆺𞆻𞆼𞆽𞆾𞆿𞇀𞇁𞇂𞇃𞇄𞇅𞇆𞇇𞇈𞇉𞇊𞇋𞇌𞇍𞇎𞇏𞇐𞇑𞇒𞇓𞇔𞇕𞇖𞇗𞇘𞇙𞇚𞇛𞇜𞇝𞇞𞇟𞇠𞇡𞇢𞇣𞇤𞇥𞇦𞇧𞇨𞇩𞇪𞇫𞇬𞇭𞇮𞇯𞇰𞇱𞇲𞇳𞇴𞇵𞇶𞇷𞇸𞇹𞇺𞇻𞇼𞇽𞇾𞇿𞈀𞈁𞈂𞈃𞈄𞈅𞈆𞈇𞈈𞈉𞈊𞈋𞈌𞈍𞈎𞈏𞈐𞈑𞈒𞈓𞈔𞈕𞈖𞈗𞈘𞈙𞈚𞈛𞈜𞈝𞈞𞈟𞈠𞈡𞈢𞈣𞈤𞈥𞈦𞈧𞈨𞈩𞈪𞈫𞈬𞈭𞈮𞈯𞈰𞈱𞈲𞈳𞈴𞈵𞈶𞈷𞈸𞈹𞈺𞈻𞈼𞈽𞈾𞈿𞉀𞉁𞉂𞉃𞉄𞉅𞉆𞉇𞉈𞉉𞉊𞉋𞉌𞉍𞉎𞉏𞉐𞉑𞉒𞉓𞉔𞉕𞉖𞉗𞉘𞉙𞉚𞉛𞉜𞉝𞉞𞉟𞉠𞉡𞉢𞉣𞉤𞉥𞉦𞉧𞉨𞉩𞉪𞉫𞉬𞉭𞉮𞉯𞉰𞉱𞉲𞉳𞉴𞉵𞉶𞉷𞉸𞉹𞉺𞉻𞉼𞉽𞉾𞉿𞊀𞊁𞊂𞊃𞊄𞊅𞊆𞊇𞊈𞊉𞊊𞊋𞊌𞊍𞊎𞊏𞊐𞊑𞊒𞊓𞊔𞊕𞊖𞊗𞊘𞊙𞊚𞊛𞊜𞊝𞊞𞊟𞊠𞊡𞊢𞊣𞊤𞊥𞊦𞊧𞊨𞊩𞊪𞊫𞊬𞊭𞊮𞊯𞊰𞊱𞊲𞊳𞊴𞊵𞊶𞊷𞊸𞊹𞊺𞊻𞊼𞊽𞊾𞊿𞋀𞋁𞋂𞋃𞋄𞋅𞋆𞋇𞋈𞋉𞋊𞋋𞋌𞋍𞋎𞋏𞋐𞋑𞋒𞋓𞋔𞋕𞋖𞋗𞋘𞋙𞋚𞋛𞋜𞋝𞋞𞋟𞋠𞋡𞋢𞋣𞋤𞋥𞋦𞋧𞋨𞋩𞋪𞋫𞋬𞋭𞋮𞋯𞋰𞋱𞋲𞋳𞋴𞋵𞋶𞋷𞋸𞋹𞋺𞋻𞋼𞋽𞋾𞋿𞌀𞌁𞌂𞌃𞌄𞌅𞌆𞌇𞌈𞌉𞌊𞌋𞌌𞌍𞌎𞌏𞌐𞌑𞌒𞌓𞌔𞌕𞌖𞌗𞌘𞌙𞌚𞌛𞌜𞌝𞌞𞌟𞌠𞌡𞌢𞌣𞌤𞌥𞌦𞌧𞌨𞌩𞌪𞌫𞌬𞌭𞌮𞌯𞌰𞌱𞌲𞌳𞌴𞌵𞌶𞌷𞌸𞌹𞌺𞌻𞌼𞌽𞌾𞌿𞍀𞍁𞍂𞍃𞍄𞍅𞍆𞍇𞍈𞍉𞍊𞍋𞍌𞍍𞍎𞍏𞍐𞍑𞍒𞍓𞍔𞍕𞍖𞍗𞍘𞍙𞍚𞍛𞍜𞍝𞍞𞍟𞍠𞍡𞍢𞍣𞍤𞍥𞍦𞍧𞍨𞍩𞍪𞍫𞍬𞍭𞍮𞍯𞍰𞍱𞍲𞍳𞍴𞍵𞍶𞍷𞍸𞍹𞍺𞍻𞍼𞍽𞍾𞍿𞎀𞎁𞎂𞎃𞎄𞎅𞎆𞎇𞎈𞎉𞎊𞎋𞎌𞎍𞎎𞎏𞎐𞎑𞎒𞎓𞎔𞎕𞎖𞎗𞎘𞎙𞎚𞎛𞎜𞎝𞎞𞎟𞎠𞎡𞎢𞎣𞎤𞎥𞎦𞎧𞎨𞎩𞎪𞎫𞎬𞎭𞎮𞎯𞎰𞎱𞎲𞎳𞎴𞎵𞎶𞎷𞎸𞎹𞎺𞎻𞎼𞎽𞎾𞎿𞏀𞏁𞏂𞏃𞏄𞏅𞏆𞏇𞏈𞏉𞏊𞏋𞏌𞏍𞏎𞏏𞏐𞏑𞏒𞏓𞏔𞏕𞏖𞏗𞏘𞏙𞏚𞏛𞏜𞏝𞏞𞏟𞏠𞏡𞏢𞏣𞏤𞏥𞏦𞏧𞏨𞏩𞏪𞏫𞏬𞏭𞏮𞏯𞏰𞏱𞏲𞏳𞏴𞏵𞏶𞏷𞏸𞏹𞏺𞏻𞏼𞏽𞏾𞏿𞐀𞐁𞐂𞐃𞐄𞐅𞐆𞐇𞐈𞐉𞐊𞐋𞐌𞐍𞐎𞐏𞐐𞐑𞐒𞐓𞐔𞐕𞐖𞐗𞐘𞐙𞐚𞐛𞐜𞐝𞐞𞐟𞐠𞐡𞐢𞐣𞐤𞐥𞐦𞐧𞐨𞐩𞐪𞐫𞐬𞐭𞐮𞐯𞐰𞐱𞐲𞐳𞐴𞐵𞐶𞐷𞐸𞐹𞐺𞐻𞐼𞐽𞐾𞐿𞑀𞑁𞑂𞑃𞑄𞑅𞑆𞑇𞑈𞑉𞑊𞑋𞑌𞑍𞑎𞑏𞑐𞑑𞑒𞑓𞑔𞑕𞑖𞑗𞑘𞑙𞑚𞑛𞑜𞑝𞑞𞑟𞑠𞑡𞑢𞑣𞑤𞑥𞑦𞑧𞑨𞑩𞑪𞑫𞑬𞑭𞑮𞑯𞑰𞑱𞑲𞑳𞑴𞑵𞑶𞑷𞑸𞑹𞑺𞑻𞑼𞑽𞑾𞑿𞒀𞒁𞒂𞒃𞒄𞒅𞒆𞒇𞒈𞒉𞒊𞒋𞒌𞒍𞒎𞒏𞒐𞒑𞒒𞒓𞒔𞒕𞒖𞒗𞒘𞒙𞒚𞒛𞒜𞒝𞒞𞒟𞒠𞒡𞒢𞒣𞒤𞒥𞒦𞒧𞒨𞒩𞒪𞒫𞒬𞒭𞒮𞒯𞒰𞒱𞒲𞒳𞒴𞒵𞒶𞒷𞒸𞒹𞒺𞒻𞒼𞒽𞒾𞒿𞓀𞓁𞓂𞓃𞓄𞓅𞓆𞓇𞓈𞓉𞓊𞓋𞓌𞓍𞓎𞓏𞓐𞓑𞓒𞓓𞓔𞓕𞓖𞓗𞓘𞓙𞓚𞓛𞓜𞓝𞓞𞓟𞓠𞓡𞓢𞓣𞓤𞓥𞓦𞓧𞓨𞓩𞓪𞓫𞓮𞓯𞓬𞓭𞓰𞓱𞓲𞓳𞓴𞓵𞓶𞓷𞓸𞓹𞓺𞓻𞓼𞓽𞓾𞓿𞔀𞔁𞔂𞔃𞔄𞔅𞔆𞔇𞔈𞔉𞔊𞔋𞔌𞔍𞔎𞔏𞔐𞔑𞔒𞔓𞔔𞔕𞔖𞔗𞔘𞔙𞔚𞔛𞔜𞔝𞔞𞔟𞔠𞔡𞔢𞔣𞔤𞔥𞔦𞔧𞔨𞔩𞔪𞔫𞔬𞔭𞔮𞔯𞔰𞔱𞔲𞔳𞔴𞔵𞔶𞔷𞔸𞔹𞔺𞔻𞔼𞔽𞔾𞔿𞕀𞕁𞕂𞕃𞕄𞕅𞕆𞕇𞕈𞕉𞕊𞕋𞕌𞕍𞕎𞕏𞕐𞕑𞕒𞕓𞕔𞕕𞕖𞕗𞕘𞕙𞕚𞕛𞕜𞕝𞕞𞕟𞕠𞕡𞕢𞕣𞕤𞕥𞕦𞕧𞕨𞕩𞕪𞕫𞕬𞕭𞕮𞕯𞕰𞕱𞕲𞕳𞕴𞕵𞕶𞕷𞕸𞕹𞕺𞕻𞕼𞕽𞕾𞕿𞖀𞖁𞖂𞖃𞖄𞖅𞖆𞖇𞖈𞖉𞖊𞖋𞖌𞖍𞖎𞖏𞖐𞖑𞖒𞖓𞖔𞖕𞖖𞖗𞖘𞖙𞖚𞖛𞖜𞖝𞖞𞖟𞖠𞖡𞖢𞖣𞖤𞖥𞖦𞖧𞖨𞖩𞖪𞖫𞖬𞖭𞖮𞖯𞖰𞖱𞖲𞖳𞖴𞖵𞖶𞖷𞖸𞖹𞖺𞖻𞖼𞖽𞖾𞖿𞗀𞗁𞗂𞗃𞗄𞗅𞗆𞗇𞗈𞗉𞗊𞗋𞗌𞗍𞗎𞗏𞗐𞗑𞗒𞗓𞗔𞗕𞗖𞗗𞗘𞗙𞗚𞗛𞗜𞗝𞗞𞗟𞗠𞗡𞗢𞗣𞗤𞗥𞗦𞗧𞗨𞗩𞗪𞗫𞗬𞗭𞗯𞗮𞗰𞗱𞗲𞗳𞗴𞗵𞗶𞗷𞗸𞗹𞗺𞗻𞗼𞗽𞗾𞗿𞘀𞘁𞘂𞘃𞘄𞘅𞘆𞘇𞘈𞘉𞘊𞘋𞘌𞘍𞘎𞘏𞘐𞘑𞘒𞘓𞘔𞘕𞘖𞘗𞘘𞘙𞘚𞘛𞘜𞘝𞘞𞘟𞘠𞘡𞘢𞘣𞘤𞘥𞘦𞘧𞘨𞘩𞘪𞘫𞘬𞘭𞘮𞘯𞘰𞘱𞘲𞘳𞘴𞘵𞘶𞘷𞘸𞘹𞘺𞘻𞘼𞘽𞘾𞘿𞙀𞙁𞙂𞙃𞙄𞙅𞙆𞙇𞙈𞙉𞙊𞙋𞙌𞙍𞙎𞙏𞙐𞙑𞙒𞙓𞙔𞙕𞙖𞙗𞙘𞙙𞙚𞙛𞙜𞙝𞙞𞙟𞙠𞙡𞙢𞙣𞙤𞙥𞙦𞙧𞙨𞙩𞙪𞙫𞙬𞙭𞙮𞙯𞙰𞙱𞙲𞙳𞙴𞙵𞙶𞙷𞙸𞙹𞙺𞙻𞙼𞙽𞙾𞙿𞚀𞚁𞚂𞚃𞚄𞚅𞚆𞚇𞚈𞚉𞚊𞚋𞚌𞚍𞚎𞚏𞚐𞚑𞚒𞚓𞚔𞚕𞚖𞚗𞚘𞚙𞚚𞚛𞚜𞚝𞚞𞚟𞚠𞚡𞚢𞚣𞚤𞚥𞚦𞚧𞚨𞚩𞚪𞚫𞚬𞚭𞚮𞚯𞚰𞚱𞚲𞚳𞚴𞚵𞚶𞚷𞚸𞚹𞚺𞚻𞚼𞚽𞚾𞚿𞛀𞛁𞛂𞛃𞛄𞛅𞛆𞛇𞛈𞛉𞛊𞛋𞛌𞛍𞛎𞛏𞛐𞛑𞛒𞛓𞛔𞛕𞛖𞛗𞛘𞛙𞛚𞛛𞛜𞛝𞛞𞛟𞛠𞛡𞛢𞛣𞛤𞛥𞛦𞛧𞛨𞛩𞛪𞛫𞛬𞛭𞛮𞛯𞛰𞛱𞛲𞛳𞛴𞛵𞛶𞛷𞛸𞛹𞛺𞛻𞛼𞛽𞛾𞛿𞜀𞜁𞜂𞜃𞜄𞜅𞜆𞜇𞜈𞜉𞜊𞜋𞜌𞜍𞜎𞜏𞜐𞜑𞜒𞜓𞜔𞜕𞜖𞜗𞜘𞜙𞜚𞜛𞜜𞜝𞜞𞜟𞜠𞜡𞜢𞜣𞜤𞜥𞜦𞜧𞜨𞜩𞜪𞜫𞜬𞜭𞜮𞜯𞜰𞜱𞜲𞜳𞜴𞜵𞜶𞜷𞜸𞜹𞜺𞜻𞜼𞜽𞜾𞜿𞝀𞝁𞝂𞝃𞝄𞝅𞝆𞝇𞝈𞝉𞝊𞝋𞝌𞝍𞝎𞝏𞝐𞝑𞝒𞝓𞝔𞝕𞝖𞝗𞝘𞝙𞝚𞝛𞝜𞝝𞝞𞝟𞝠𞝡𞝢𞝣𞝤𞝥𞝦𞝧𞝨𞝩𞝪𞝫𞝬𞝭𞝮𞝯𞝰𞝱𞝲𞝳𞝴𞝵𞝶𞝷𞝸𞝹𞝺𞝻𞝼𞝽𞝾𞝿𞞀𞞁𞞂𞞃𞞄𞞅𞞆𞞇𞞈𞞉𞞊𞞋𞞌𞞍𞞎𞞏𞞐𞞑𞞒𞞓𞞔𞞕𞞖𞞗𞞘𞞙𞞚𞞛𞞜𞞝𞞞𞞟𞞠𞞡𞞢𞞣𞞤𞞥𞞦𞞧𞞨𞞩𞞪𞞫𞞬𞞭𞞮𞞯𞞰𞞱𞞲𞞳𞞴𞞵𞞶𞞷𞞸𞞹𞞺𞞻𞞼𞞽𞞾𞞿𞟀𞟁𞟂𞟃𞟄𞟅𞟆𞟇𞟈𞟉𞟊𞟋𞟌𞟍𞟎𞟏𞟐𞟑𞟒𞟓𞟔𞟕𞟖𞟗𞟘𞟙𞟚𞟛𞟜𞟝𞟞𞟟𞟠𞟡𞟢𞟣𞟤𞟥𞟦𞟧𞟨𞟩𞟪𞟫𞟬𞟭𞟮𞟯𞟰𞟱𞟲𞟳𞟴𞟵𞟶𞟷𞟸𞟹𞟺𞟻𞟼𞟽𞟾𞟿𞠀𞠁𞠂𞠃𞠄𞠅𞠆𞠇𞠈𞠉𞠊𞠋𞠌𞠍𞠎𞠏𞠐𞠑𞠒𞠓𞠔𞠕𞠖𞠗𞠘𞠙𞠚𞠛𞠜𞠝𞠞𞠟𞠠𞠡𞠢𞠣𞠤𞠥𞠦𞠧𞠨𞠩𞠪𞠫𞠬𞠭𞠮𞠯𞠰𞠱𞠲𞠳𞠴𞠵𞠶𞠷𞠸𞠹𞠺𞠻𞠼𞠽𞠾𞠿𞡀𞡁𞡂𞡃𞡄𞡅𞡆𞡇𞡈𞡉𞡊𞡋𞡌𞡍𞡎𞡏𞡐𞡑𞡒𞡓𞡔𞡕𞡖𞡗𞡘𞡙𞡚𞡛𞡜𞡝𞡞𞡟𞡠𞡡𞡢𞡣𞡤𞡥𞡦𞡧𞡨𞡩𞡪𞡫𞡬𞡭𞡮𞡯𞡰𞡱𞡲𞡳𞡴𞡵𞡶𞡷𞡸𞡹𞡺𞡻𞡼𞡽𞡾𞡿𞢀𞢁𞢂𞢃𞢄𞢅𞢆𞢇𞢈𞢉𞢊𞢋𞢌𞢍𞢎𞢏𞢐𞢑𞢒𞢓𞢔𞢕𞢖𞢗𞢘𞢙𞢚𞢛𞢜𞢝𞢞𞢟𞢠𞢡𞢢𞢣𞢤𞢥𞢦𞢧𞢨𞢩𞢪𞢫𞢬𞢭𞢮𞢯𞢰𞢱𞢲𞢳𞢴𞢵𞢶𞢷𞢸𞢹𞢺𞢻𞢼𞢽𞢾𞢿𞣀𞣁𞣂𞣃𞣄𞣅𞣆𞣇𞣈𞣉𞣊𞣋𞣌𞣍𞣎𞣏𞣐𞣑𞣒𞣓𞣔𞣕𞣖𞣗𞣘𞣙𞣚𞣛𞣜𞣝𞣞𞣟𞣠𞣡𞣢𞣣𞣤𞣥𞣦𞣧𞣨𞣩𞣪𞣫𞣬𞣭𞣮𞣯𞣰𞣱𞣲𞣳𞣴𞣵𞣶𞣷𞣸𞣹𞣺𞣻𞣼𞣽𞣾𞣿𞤀𞤁𞤂𞤃𞤄𞤅𞤆𞤇𞤈𞤉𞤊𞤋𞤌𞤍𞤎𞤏𞤐𞤑𞤒𞤓𞤔𞤕𞤖𞤗𞤘𞤙𞤚𞤛𞤜𞤝𞤞𞤟𞤠𞤡𞤢𞤣𞤤𞤥𞤦𞤧𞤨𞤩𞤪𞤫𞤬𞤭𞤮𞤯𞤰𞤱𞤲𞤳𞤴𞤵𞤶𞤷𞤸𞤹𞤺𞤻𞤼𞤽𞤾𞤿𞥀𞥁𞥂𞥃𞥊𞥄𞥅𞥆𞥇𞥈𞥉𞥋𞥌𞥍𞥎𞥏𞥐𞥑𞥒𞥓𞥔𞥕𞥖𞥗𞥘𞥙𞥚𞥛𞥜𞥝𞥞𞥟𞥠𞥡𞥢𞥣𞥤𞥥𞥦𞥧𞥨𞥩𞥪𞥫𞥬𞥭𞥮𞥯𞥰𞥱𞥲𞥳𞥴𞥵𞥶𞥷𞥸𞥹𞥺𞥻𞥼𞥽𞥾𞥿𞦀𞦁𞦂𞦃𞦄𞦅𞦆𞦇𞦈𞦉𞦊𞦋𞦌𞦍𞦎𞦏𞦐𞦑𞦒𞦓𞦔𞦕𞦖𞦗𞦘𞦙𞦚𞦛𞦜𞦝𞦞𞦟𞦠𞦡𞦢𞦣𞦤𞦥𞦦𞦧𞦨𞦩𞦪𞦫𞦬𞦭𞦮𞦯𞦰𞦱𞦲𞦳𞦴𞦵𞦶𞦷𞦸𞦹𞦺𞦻𞦼𞦽𞦾𞦿𞧀𞧁𞧂𞧃𞧄𞧅𞧆𞧇𞧈𞧉𞧊𞧋𞧌𞧍𞧎𞧏𞧐𞧑𞧒𞧓𞧔𞧕𞧖𞧗𞧘𞧙𞧚𞧛𞧜𞧝𞧞𞧟𞧠𞧡𞧢𞧣𞧤𞧥𞧦𞧧𞧨𞧩𞧪𞧫𞧬𞧭𞧮𞧯𞧰𞧱𞧲𞧳𞧴𞧵𞧶𞧷𞧸𞧹𞧺𞧻𞧼𞧽𞧾𞧿𞨀𞨁𞨂𞨃𞨄𞨅𞨆𞨇𞨈𞨉𞨊𞨋𞨌𞨍𞨎𞨏𞨐𞨑𞨒𞨓𞨔𞨕𞨖𞨗𞨘𞨙𞨚𞨛𞨜𞨝𞨞𞨟𞨠𞨡𞨢𞨣𞨤𞨥𞨦𞨧𞨨𞨩𞨪𞨫𞨬𞨭𞨮𞨯𞨰𞨱𞨲𞨳𞨴𞨵𞨶𞨷𞨸𞨹𞨺𞨻𞨼𞨽𞨾𞨿𞩀𞩁𞩂𞩃𞩄𞩅𞩆𞩇𞩈𞩉𞩊𞩋𞩌𞩍𞩎𞩏𞩐𞩑𞩒𞩓𞩔𞩕𞩖𞩗𞩘𞩙𞩚𞩛𞩜𞩝𞩞𞩟𞩠𞩡𞩢𞩣𞩤𞩥𞩦𞩧𞩨𞩩𞩪𞩫𞩬𞩭𞩮𞩯𞩰𞩱𞩲𞩳𞩴𞩵𞩶𞩷𞩸𞩹𞩺𞩻𞩼𞩽𞩾𞩿𞪀𞪁𞪂𞪃𞪄𞪅𞪆𞪇𞪈𞪉𞪊𞪋𞪌𞪍𞪎𞪏𞪐𞪑𞪒𞪓𞪔𞪕𞪖𞪗𞪘𞪙𞪚𞪛𞪜𞪝𞪞𞪟𞪠𞪡𞪢𞪣𞪤𞪥𞪦𞪧𞪨𞪩𞪪𞪫𞪬𞪭𞪮𞪯𞪰𞪱𞪲𞪳𞪴𞪵𞪶𞪷𞪸𞪹𞪺𞪻𞪼𞪽𞪾𞪿𞫀𞫁𞫂𞫃𞫄𞫅𞫆𞫇𞫈𞫉𞫊𞫋𞫌𞫍𞫎𞫏𞫐𞫑𞫒𞫓𞫔𞫕𞫖𞫗𞫘𞫙𞫚𞫛𞫜𞫝𞫞𞫟𞫠𞫡𞫢𞫣𞫤𞫥𞫦𞫧𞫨𞫩𞫪𞫫𞫬𞫭𞫮𞫯𞫰𞫱𞫲𞫳𞫴𞫵𞫶𞫷𞫸𞫹𞫺𞫻𞫼𞫽𞫾𞫿𞬀𞬁𞬂𞬃𞬄𞬅𞬆𞬇𞬈𞬉𞬊𞬋𞬌𞬍𞬎𞬏𞬐𞬑𞬒𞬓𞬔𞬕𞬖𞬗𞬘𞬙𞬚𞬛𞬜𞬝𞬞𞬟𞬠𞬡𞬢𞬣𞬤𞬥𞬦𞬧𞬨𞬩𞬪𞬫𞬬𞬭𞬮𞬯𞬰𞬱𞬲𞬳𞬴𞬵𞬶𞬷𞬸𞬹𞬺𞬻𞬼𞬽𞬾𞬿𞭀𞭁𞭂𞭃𞭄𞭅𞭆𞭇𞭈𞭉𞭊𞭋𞭌𞭍𞭎𞭏𞭐𞭑𞭒𞭓𞭔𞭕𞭖𞭗𞭘𞭙𞭚𞭛𞭜𞭝𞭞𞭟𞭠𞭡𞭢𞭣𞭤𞭥𞭦𞭧𞭨𞭩𞭪𞭫𞭬𞭭𞭮𞭯𞭰𞭱𞭲

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 (844) 457-0614.

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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 (844) 457-0614.

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 (844) 457-0614

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।
दुभाषिये से बात करने के लिए, कॉल करें ।

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 (844) 457-0614.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 457-0614.

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Language Access Services:

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- Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ ។
- Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 457-0614.
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- Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (844) 457-0614
- Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bína'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nı́ł hodoonih t'áadoo báááh ilínígóó.
Ata' halne'ígíí la' bich'ı́' hadeesdzih nínízingo kojı́' hodiılnih
- 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
- Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 457-0614 bilbilla.
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Language Access Services:

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Language Access Services:

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lófèfẹ̀. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (844) 457-0614.

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