




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/5YVFSH08152022L00478MG02>. 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 (800) 888-2108 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$500/student for In- <a href="#">Network Providers</a> . \$1,000/student 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.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care, <a href="#">Specialist</a> visit for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . <a href="#">Preventive Care</a> for In- <a href="#">Network Providers</a> . Tier 1, Tier 2, Tier 3 for <a href="#">Prescription Drugs</a> for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . Laboratory services for In- <a href="#">Network Providers</a> . All mental health, behavioral health, and substance abuse services for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> . All pediatric dental services and all pediatric vision services 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 preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . 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> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,700/student for In- <a href="#">Network Providers</a> . \$17,400/student 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.   |
| What is not included  | <a href="#">Premiums</a> , <a href="#">balance-billing</a>   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

|  |  |  |
|--|--|--|
| in the <a href="#">out-of-pocket limit</a> ?                                 | charges, and health care this <a href="#">plan</a> doesn't cover.  |  |
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?planstate=CA&amp;plantype=PPOSTUD&amp;planname=Blue+Cross+PPO+Prudent+Buyer+-+Student+Health">http://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?planstate=CA&amp;plantype=PPOSTUD&amp;planname=Blue+Cross+PPO+Prudent+Buyer+-+Student+Health</a> or call (800) 888-2108 for a list of <a href="#">network providers</a> . | 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 out-of- <a href="#">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="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">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  |
|--|--|---|---|---|
|  |  | In-Network Provider (You will pay the least)  | 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       | \$20/visit <a href="#">deductible</a> does not apply  | \$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply | -----none-----  |
|  | <a href="#">Specialist</a> visit                       | \$40/visit <a href="#">deductible</a> does not apply  | \$40/visit then 40% <a href="#">coinsurance deductible</a> does not apply | -----none-----  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 40% <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)    | 20% <a href="#">coinsurance deductible</a> does not apply to laboratory services<br>20% <a href="#">coinsurance for x-rays and other diagnostic tests</a> | \$10/visit then 40% <a href="#">coinsurance</a>                           | Precertification required for some services. For details about precertification, see the certificate.   |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>   | \$10/visit then 40% <a href="#">coinsurance</a>                           | Precertification required for some services. For details about precertification, see the certificate.   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5YVFSH08152022L00478MG02>

| Common Medical Event   | Services You May Need   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|---|---|---|
|  |   | In-Network Provider (You will pay the least)  | Non-Network Provider (You will pay the most)                              |   |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/143/TraditionalABC3TierStudentHealthPlan.pdf">https://fm.formularynavigator.com/FBO/143/TraditionalABC3TierStudentHealthPlan.pdf</a></p> <p>Traditional Open Drug List <b>Error! Hyperlink reference not valid.</b></p> | Tier 1 - Typically Generic  | \$15/prescription <a href="#">deductible</a> does not apply (retail) and \$37.50/prescription <a href="#">deductible</a> does not apply (home delivery) | \$15/prescription <a href="#">deductible</a> does not apply (retail)      | <p>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).</p> |
|  | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | \$40/prescription <a href="#">deductible</a> does not apply (retail) and \$100/prescription <a href="#">deductible</a> does not apply (home delivery)   | \$40/prescription <a href="#">deductible</a> does not apply (retail)      |   |
|  | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | \$60/prescription <a href="#">deductible</a> does not apply (retail) and \$150/prescription <a href="#">deductible</a> does not apply (home delivery)   | \$60/prescription <a href="#">deductible</a> does not apply (retail)      |   |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center)                                      | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | -----none-----  |
|  | Physician/surgeon fees  | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Precertification required for most surgical procedures. For details about precertification, see the certificate.  |
| <p><b>If you need immediate medical attention</b></p>  | <a href="#">Emergency room care</a>   | \$150/visit then 20% <a href="#">coinsurance</a>  | Covered as In- <a href="#">Network</a>                                    | Copay waived if admitted.   |
|  | <a href="#">Emergency medical transportation</a>                                    | \$150/trip then 20% <a href="#">coinsurance</a>   | Covered as In- <a href="#">Network</a>                                    | -----none-----  |
|  | <a href="#">Urgent care</a>   | <a href="#">\$20/visit deductible</a> does not apply  | \$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply | -----none-----  |
| <p><b>If you have a hospital stay</b></p>  | Facility fee (e.g., hospital room)  | 20% <a href="#">coinsurance</a>   | \$500/admission then 40% <a href="#">coinsurance</a>                      | <p>Precertification required for inpatient facility admissions and most surgical procedures. For details about precertification, see the certificate.</p>             |
|  | Physician/surgeon fees  | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   |   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5YVFSH08152022L00478MG02>

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|---|---|--|--|
|   |   | In-Network Provider (You will pay the least)  | Non-Network Provider (You will pay the most)   |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit<br>\$20/visit <a href="#">deductible</a> does not apply<br>Other Outpatient<br>20% <a href="#">coinsurance deductible</a> does not apply | Office Visit<br>\$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply<br>Other Outpatient<br>40% <a href="#">coinsurance deductible</a> does not apply | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----   |
|   | Inpatient services                        | 20% <a href="#">coinsurance deductible</a> does not apply   | \$500/admission then 40% <a href="#">coinsurance deductible</a> does not apply   | Precertification required for inpatient facility admissions. For details about precertification, see the certificate.  |
| If you are pregnant   | Office visits                             | \$20/visit <a href="#">deductible</a> does not apply  | \$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply  | No charge for Preventive prenatal and postnatal care for In- <a href="#">Network Providers</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).                     |
|   | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  |  |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>   | \$500/admission then 40% <a href="#">coinsurance</a>   |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 100 visits/benefit period. Precertification required. For details about precertification, see the certificate. Limit applies separately to <a href="#">Rehabilitation</a> and <a href="#">Habilitation</a> services. |
|   | <a href="#">Rehabilitation services</a>   | Office Visit<br>\$20/visit <a href="#">deductible</a> does not apply<br><br>Other Outpatient<br>20% <a href="#">coinsurance</a>                       | Office Visit<br>\$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply<br>Other Outpatient<br>40% <a href="#">coinsurance</a>                           | *See Therapy Services section<br>See “If you have a hospital stay” for applicable Inpatient cost share.  |
|   | <a href="#">Habilitation services</a>     | Office Visit<br>\$20/visit <a href="#">deductible</a> does not apply<br><br>Other Outpatient<br>20% <a href="#">coinsurance</a>                       | Office Visit<br>\$20/visit then 40% <a href="#">coinsurance deductible</a> does not apply<br>Other Outpatient<br>40% <a href="#">coinsurance</a>                           |  |

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| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)         |  |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>              | \$500/admission then 40% <a href="#">coinsurance</a> | 100 days limit/benefit period. Precertification required. For details about precertification, see the certificate. |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                      | *See <a href="#">Durable Medical Equipment Section</a>   |
|   | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                      | Precertification required. For details about precertification, see the certificate.                                |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No charge                                    | No charge  | *See Vision Services section   |
|   | Children's glasses                        | No charge                                    | No charge  |  |
|   | Children's dental check-up                | No charge                                    | No charge  | *See Dental Services section   |

### 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
- Private-duty nursing
- Weight loss programs
- Dental care (adult)
- Routine eye care (adult)
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes

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

- Abortion
- Chiropractic care
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Acupuncture
- Hearing aids when needed due to hearing loss resulting from infection or injury
- Bariatric surgery
- Infertility treatment

**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: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357). Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565,

\* For more information about limitations and exceptions, see [plan](#) or policy document at

<https://eoc.anthem.com/eocdps/ca/5YVFSH08152022L00478MG02>

[www.cciio.cms.gov](http://www.cciio.cms.gov). 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357)

California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), [www.insurance.ca.gov/](http://www.insurance.ca.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.

**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/5YVFSH08152022L00478MG02>



## 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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,400        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,970</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,400        |
| <a href="#">Coinsurance</a>       | \$20           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,440</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> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other <a href="#">coinsurance</a>                             | 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:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$400          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,000</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 (800) 888-2108

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 888-2108 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 (800) 888-2108.

**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՝ (800) 888-2108:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̄ò ni dyí-b̄èdjèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò djò gbo wùdù ke, djá (800) 888-2108.

**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 (800) 888-2108 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 888-2108 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 (800) 888-2108。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 888-2108.

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## Language Access Services:

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