


## Newell Operating Company: Consumer Plan



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/aso>. 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 (844) 810-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000/single or \$6,000/family for In- <a href="#">Network Providers</a> .  \$6,000/single or \$12,000/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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive Care</a> . For more information see below.	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?	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> ?	\$6,000/single or \$6,000/single within a family or \$9,000/family for In- <a href="#">Network Providers</a> .  \$12,000/single or \$12,000/single within a family or \$18,000/family for Non- <a href="#">Network Providers</a> .  Health Savings Account: Access to an HSA is available for eligible participants (not COBRA participants or retirees) when enrolled on this plan. Funding may be used for reimbursements of eligible health expenses. Employee-only level coverage has \$250/ annual	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.

	HSA funding. Employee-plus-one or more coverage tiers have access to \$500/ annual HSA funding. Visit Fidelity at <a href="http://www.netbenefits.com">www.netbenefits.com</a> or call 1-833-252-2244 for additional information.	
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , certain specialty drugs managed by Prudent Rx, <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and cost containment penalties (for failure to pre-certify).	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, for a list of in-network providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 897-1337.  Yes, for prescription drugs: CVS Health. For a list of network retail and mail pharmacies, log on to <a href="http://www.caremark.com">www.caremark.com</a> or call Customer Service at 1-800-213-0879.	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="#">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
		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% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	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

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

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)	
				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</a>	50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required, \$300 penalty if services are not pre-certified.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>  Note: If a prescription is attempted out of national pharmacy network, it will reject. Please visit <a href="http://www.caremark.com">www.caremark.com</a> for more details.	Typically Generic (Tier 1)	20% <a href="#">coinsurance</a> (retail and home delivery)	20% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	Maintenance medications: Required to be filled through CVS90 program or Home Delivery Retail: Limited to a 30-day supply CVS90: Members may only get 90-day Maintenance Medication at CVS/pharmacy, COSTCO Pharmacies, Target, Kroger, and Select independents. Please visit Caremark.com to verify your closest pharmacy for 90-day. These are subject to state laws – based off the state where the pharmacy is located, some of these requirements may be affected. Home Delivery: Limited to a 90-day supply. Specialty: Available in a 30-day supply through CVS Specialty Pharmacy Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at <a href="http://www.caremark.com">www.caremark.com</a> . Prescription drug charges apply to the Medical deductible and out-of-pocket limit.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	20% <a href="#">coinsurance</a> (retail and home delivery)	20% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	40% <a href="#">coinsurance</a> (retail and home delivery)	40% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	For Specialty Drugs, enroll in PrudentRx to get your medication at \$0 after your <a href="#">deductible</a> is met. If you do not enroll you are subject to a 30% cost share. If your Specialty Medication is not offered by PrudentRx you will pay the coinsurance with a \$250 Max. (retail and home delivery)	Not covered (retail and home delivery)	

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required for outpatient surgery, except for surgery performed in a physician's office; \$300 penalty if services are not pre-certified.
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)	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required for outpatient surgery, except for surgery performed in a physician's office; \$300 penalty if services are not pre-certified.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	Pre-certification is required; \$300 penalty if services are not pre-certified.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required; \$300 penalty if services are not pre-certified.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required; \$300 penalty if services are not pre-certified.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	-----none-----
	Inpatient services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Pre-certification is required for inpatient mental health/substance abuse treatment (includes residential treatment facility services). Pre-certification is also required for partial hospitalization, and intensive outpatient treatment, and ABA therapy, for mental health and substance abuse treatment; \$300 penalty if services are not pre-certified.
	Office visits	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests

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If you are pregnant	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
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 help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	200 visits/benefit period for Home Health and Private Duty Nursing combined.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	30 visits limit not combined with any other therapy. Limit combined institutional/professional. Limit combined in and out of network.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required for inpatient rehabilitation facility and for outpatient rehabilitation or habilitative services (physical, occupational, and speech therapy) in excess of thirty (30) visits per calendar year. \$300 penalty if services are not pre-certified.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required, \$300 penalty if services are not pre-certified.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required for DME exceeding \$1,000; \$300 penalty if services are not pre-certified.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-certification is required; \$300 penalty if services are not pre-certified.
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	

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

## 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](#).)

- |                                                                                               |                                                                                                                  |                                                                                                                                     |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Routine eye care</li><li>• Cosmetic surgery</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care unless you have been diagnosed with diabetes</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li></ul>                                                                    |
| <ul style="list-style-type: none"><li>• Glasses for a child</li></ul>                         | <ul style="list-style-type: none"><li>• Dental care</li><li>• Eye exam (Child)</li></ul>                         | <ul style="list-style-type: none"><li>• Weight loss programs</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> |

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

- |                                                                                                                                                                                       |                                                                                                                                                     |                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion</li><li>• Hearing aids 1 pair/36 months</li><li>• Private-duty nursing 200 visits/benefit period combined with Home Health</li></ul> | <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Infertility treatment \$25,000 maximum/lifetime</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care 30 visits/benefit period</li><li>• Gender affirming care</li><li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li></ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx), 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 on how 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 105568, Atlanta GA 30348-5568

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

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)

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

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 the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.



## 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
This EXAMPLE event includes services like: <a href="#">Specialist</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		This EXAMPLE event includes services like: <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000	<a href="#">Deductibles</a>	\$3,000	<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,900	<a href="#">Coinsurance</a>	\$500	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$4,960	The total Joe would pay is	\$3,520	The total Mia would pay is	\$2,800

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) 810-2583

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 810-2583 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) 810-2583.

**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) 810-2583:

**Bassa (Bàsɔ̀ Wùdù):** M̐ dyi dyi-diè-djé b̐ bédjé bá céè-djé nià kɛ dyí ní, ɔ m̀b̀ ni dyí-bédjéìn-djé b̐ m̐ kɛ gbo-kpá-kpá kè b̐ kp̐ djé m̐ bídí-wùdùùn b̐ pídyi. B̐ m̐ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d̐á (800) 810-2583.

**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) 810-2583 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (800) 810-2583 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) 810-2583。

**Dinka (Dinka):** Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te k̄ɔr yin ba jam wēnē ran ye thok geryic, ke yin c̄ɔl (800) 810-2583.

**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 (800) 810-2583.

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## Language Access Services:

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## Language Access Services:

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## Language Access Services:

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