



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, www.anthem.com/ca/calpers. 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 (877) 737-7776 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000 /individual or \$2,000 /family. All 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 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 . Whichever is met first.
Are there services covered before you meet your deductible ?	Yes. Prescription Drugs , Preventive care , Primary Care visit, and Specialist visit for In- Network Providers .	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?	Yes. \$50 /visit for Emergency room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Coinsurance may apply for all other services provided in the ER.
What is the out-of-pocket limit for this plan ?	\$3,000 /single or \$6,000 /family for In- Network Providers . \$0 /single or \$0 /family for Out-of- Network providers . This plan has a separate Out of Pocket Maximum for Prescription Drugs of \$2,000 /single or \$4,000 /family, \$1,000 Home delivery.	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. Whichever is met first.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, deductible, copay, 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 ?	Yes, Select PPO Preferred Providers. See www.anthem.com/ca/calpers or call (877) 737-7776 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	\$10/visit if enrolled with a personal doctor deductible does not apply	40% coinsurance	\$35 visit if not enrolled with a personal doctor/PCP.
	Specialist visit	\$35/visit deductible does not apply	40% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge	40% coinsurance	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	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior authorization may be required.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$5/prescription deductible does not apply (retail) and \$10/prescription deductible does not apply (home delivery)	Not covered	Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Tier 2 - Typically Preferred Brand	\$20/prescription deductible does not apply (retail) and \$40/prescription deductible does not apply (home delivery)	Not covered	

* For more information about limitations and exceptions, see [plan](#) or policy document at www.anthem.com/ca/calpers.

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)	
More information about prescription drug coverage is available at http://www.optumrx.com/calpers	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$50/prescription deductible does not apply (retail) and \$100/prescription deductible does not apply (home delivery)	Not covered	
	Tier 4 - Typically Specialty (brand and generic)	Specialty follows the tier structure above.	Not covered	
If you have outpatient surgery	Facility fee (e.g., hospital, ambulatory surgery center)	20% coinsurance	40% coinsurance	Services and supplies for certain outpatient surgeries may be limited if not done at an ambulatory surgery center. For example: Colonoscopy limited to \$1,500 per procedure, Cataract surgery limited to \$2,000 per procedure. Check with your plan for additional details. Benefits limited to \$350 for ASC per day for Non-PPO providers .
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	20% coinsurance Emergency room services	Covered as In- Network	If admitted directly to hospital \$50 ER deductible waived.
	Emergency medical transportation	20% coinsurance	Covered as In- Network	You must be taken to the nearest facility that can provide care for your condition. Ambulance services are subject to Medical Necessity reviews.
	Urgent care	\$35/visit deductible does not apply 20% coinsurance	40% coinsurance	Coinsurance for all other services provided during visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Hip and Knee joint replacement surgery will be limited to \$35,000 per procedure. A subset of participating hospitals that meets this maximum benefit coverage is available. Check with your plan for additional details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at www.anthem.com/ca/calpers.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$10/visit <u>deductible</u> does not apply Other Outpatient 20% <u>coinsurance</u>	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	-----none-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	20% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network Providers</u> . 40% <u>coinsurance</u> for Inpatient Physician Fee Out-of- <u>Network Providers</u> . Prior authorization required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Childbirth/delivery facility services <u>Coinurance</u> and deductible waived if enrolled under Future Moms program. Alternative Birthing Center may be used instead of hospitalization.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	45 visits/benefit period. A visit is defined as 4 hours or less.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	*See Therapy Services section
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> first 10 days 30% <u>coinsurance</u> following 90 days	40% <u>coinsurance</u>	100 days limit/benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Specific Durable Medical Equipment requires Precertification
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

* For more information about limitations and exceptions, see [plan](#) or policy document at www.anthem.com/ca/calpers.

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 |
| • Eye exams for a child | • Glasses for a child | • Infertility treatment |
| • Long- term care | • Private-duty nursing | • 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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|---|--|---|
| • Acupuncture Rider 20 visits/benefit period combined with Chiropractic care. | • Bariatric surgery | • Chiropractic care Rider 20 visits/benefit period combined with Acupuncture. |
| • Hearing aids \$1,000 maximum every 36 months. | • Most coverage provided outside the United States. See www.bcbsglobalcore.com | |

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](#), P.O. Box 60007, Los Angeles, CA 90060-0007

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

California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, www.healthhelp.ca.gov, helpline@dmhc.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](#).

* For more information about limitations and exceptions, see [plan](#) or policy document at www.anthem.com/ca/calpers.

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	\$1,000
☐ Specialist copayment	\$0
☐ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,300

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

☐ The plan's overall deductible	\$1,000
☐ Primary care PCP copayment	\$10
☐ 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	\$2,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$80
Coinsurance	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,250

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

☐ The plan's overall deductible	\$1,000
☐ Emergency Room copayment	\$50
☐ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$50
Coinsurance	\$780
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Mia would pay is	\$1,930

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 (877) 737-7776

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 737-7776 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 (877) 737-7776.

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՝ (877) 737-7776:

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

Language Access Services:

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Language Access Services:

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