




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, see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-888-901-4636 (TTY: 711). 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 1-888-901-4636 (TTY: 711) to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$1,500 Individual / \$3,000 Family  | 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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .   |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.   | 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> .  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$6,850 Individual / \$13,700 Family   | 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.  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-888-901-4636 (TTY: 711) 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 <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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | Yes, but you may self-refer to certain <a href="#">specialists</a> .   | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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  |
|---|--|--|---|---|
|   |  | Network Provider<br>(You will pay the least)   | Non-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness       | \$30 / visit, then 25% <a href="#">coinsurance</a>   | Not covered                                     | <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit).                   |
|   | <a href="#">Specialist</a> visit                       | \$75 / visit, then 25% <a href="#">coinsurance</a>   | Not covered                                     | <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit).                   |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge, <a href="#">deductible</a> does not apply.  | Not covered                                     | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | X-ray: No charge up to \$500, then 25% <a href="#">coinsurance</a><br>Lab tests: No charge up to \$500, then 25% <a href="#">coinsurance</a> | Not covered                                     | None  |
|   | Imaging (CT/PET scans, MRIs)                           | No charge up to \$500, then 25% <a href="#">coinsurance</a>  | Not covered                                     | <a href="#">Preauthorization</a> required or will not be covered.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Preferred generic drugs                                | \$10 (retail); \$20 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                 | Not covered                                     | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.  |
|   | Preferred brand drugs                                  | \$50 (retail); \$100 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                | Not covered                                     | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines.  |
|   | Non-preferred drugs                                    | \$50 (retail); \$100 (mail order) / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply.                                | Not covered                                     | Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.   |
|   | <a href="#">Specialty drugs</a>                        | Applicable Preferred generic, Preferred brand or Non-preferred <a href="#">cost shares</a> apply.  | Not covered                                     | Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through the exception process.   |

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)                                 | Non-Network Provider<br>(You will pay the most)                              |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | \$100 / visit, then 25% <a href="#">coinsurance</a>                          | Not covered  | None  |
|   | Physician/surgeon fees                           | 25% <a href="#">coinsurance</a>  | Not covered  | None  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 25% <a href="#">coinsurance</a>  | 25% <a href="#">coinsurance</a>  | You must notify Kaiser Permanente within 24 hours if admitted to a <a href="#">Non-Network Provider</a> ; limited to initial emergency only.  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply. | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply. | None  |
|   | <a href="#">Urgent care</a>                      | \$30 / visit, then 25% <a href="#">coinsurance</a>                           | 25% <a href="#">coinsurance</a>  | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 25% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> required or will not be covered.   |
|   | Physician/surgeon fees                           | 25% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> required or will not be covered.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 / visit, then 25% <a href="#">coinsurance</a>                           | Not covered  | <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit). |
|   | Inpatient services                               | 25% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> required or will not be covered.   |
| If you are pregnant   | Office visits                                    | 25% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                     |
|   | Childbirth/delivery professional services        | 25% <a href="#">coinsurance</a>  | Not covered  | You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <a href="#">cost shares</a> are separate from that of the mother.           |
|   | Childbirth/delivery facility services            | 25% <a href="#">coinsurance</a>  | Not covered  | You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <a href="#">cost shares</a> are separate from that of the mother.           |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | Network Provider<br>(You will pay the least)   | Non-Network Provider<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No charge, <a href="#">deductible</a> does not apply.  | Not covered                                     | <a href="#">Preauthorization</a> required or will not be covered.   |
|  | <a href="#">Rehabilitation services</a>   | Outpatient: \$75 / visit, then 25% <a href="#">coinsurance</a><br>Inpatient: 25% <a href="#">coinsurance</a> | Not covered                                     | Outpatient: 45 visit limit / year, combined with <a href="#">Habilitation services</a> . <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit). Inpatient: 30-day limit / year, combined with <a href="#">Habilitation services</a> . <a href="#">Preauthorization</a> required or will not be covered.  |
|  | <a href="#">Habilitation services</a>     | Outpatient: \$75 / visit, then 25% <a href="#">coinsurance</a><br>Inpatient: 25% <a href="#">coinsurance</a> | Not covered                                     | Outpatient: 45 visit limit / year, combined with <a href="#">Rehabilitation services</a> . <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit). Inpatient: <a href="#">Preauthorization</a> required or will not be covered. Inpatient: 30-day limit / year, combined with <a href="#">Rehabilitation services</a> . <a href="#">Preauthorization</a> required or will not be covered. |
|  | <a href="#">Skilled nursing care</a>      | 25% <a href="#">coinsurance</a>  | Not covered                                     | 60-day limit / year. <a href="#">Preauthorization</a> required or will not be covered.  |
|  | <a href="#">Durable medical equipment</a> | No charge, <a href="#">deductible</a> does not apply.  | Not covered                                     | Subject to <a href="#">formulary</a> guidelines. <a href="#">Preauthorization</a> required or will not be covered.  |
|  | <a href="#">Hospice services</a>          | No charge, <a href="#">deductible</a> does not apply.  | Not covered                                     | <a href="#">Preauthorization</a> required or will not be covered.   |
| If your child needs dental or eye care                         | Children's eye exam                       | \$30 / visit, then 25% <a href="#">coinsurance</a> for refractive exam.                                      | Not covered                                     | <a href="#">Deductible</a> and <a href="#">coinsurance</a> do not apply to any combination of the first 4 outpatient visits / year ( <a href="#">preventive care</a> does not count towards visit limit).   |
|  | Children's glasses                        | Not covered  | Not covered                                     | None  |
|  | 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](#).)

- |                                 |  |                        |
|---------------------------------|--|------------------------|
| • Bariatric surgery             | • Infertility treatment                              | • Private-duty nursing |
| • Children’s glasses            | • Long-term care                                     | • Routine foot care    |
| • Cosmetic surgery              | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult and child) |  |                        |

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

- |   |  |                            |
|---|--|----------------------------|
| • Acupuncture (8 visit limit / year)        | • Hearing aids (\$3,000 limit / ear / 36 months) | • Routine eye care (Adult) |
| • Chiropractic care (10 visit limit / year) |  |                            |

**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 shown in the chart below. 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 the agencies in the chart below.

### Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

|  |   |
|--|---|
| Kaiser Permanente Member Services  | 1-888-901-4636 (TTY:711) or <a href="http://www.kp.org">www.kp.org</a>                                    |
| Department of Labor’s Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| Washington Department of Insurance   | 1-800-562-6900 or <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>                          |

### 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](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636 (TTY: 711).

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500    |
| ■ <a href="#">Specialist cost-sharing</a>                       | \$75 + 25% |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%        |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 25%        |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Peg would pay is</b> | <b>\$4,030</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> | \$1,500    |
| ■ <a href="#">Specialist cost-sharing</a>                       | \$75 + 25% |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%        |
| ■ Other (blood work) <a href="#">coinsurance</a>                | 25%        |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,100        |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,000</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> | \$1,500    |
| ■ <a href="#">Specialist cost-sharing</a>                       | \$75 + 25% |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%        |
| ■ Other (x-ray) <a href="#">coinsurance</a>                     | 25%        |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$70           |
| <a href="#">Coinsurance</a>       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,770</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (“Kaiser Permanente”) comply with applicable Federal and Washington state civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
  - Assistive devices (magnifiers, Pocket Talkers, and other aids)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at **1-888-901-4636** (TTY **711**).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at **kp.org/wa/feedback**. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697** (TDD) Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **<https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **<https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>**



# Multi-language Interpreter Services

**English: ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636 (TTY 711)**.

**Español (Spanish): ATENCIÓN:** Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636 (TTY 711)**.

**中文 (Chinese) : 注意 :** 如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636 (TTY 711)**。

**Tiếng Việt (Vietnamese): CHÚ Ý:** Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636 (TTY 711)**.

**한국어 (Korean): 참고:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636(TTY 711)**번으로 문의하십시오.

**Русский (Russian): ВНИМАНИЕ!** Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636 (TTY 711)**.

**Tagalog: PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636 (TTY 711)**.

**Українська (Ukrainian): УВАГА!** Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636 (TTY 711)**.

**ភាសាខ្មែរ (Khmer): សូមយកចិត្តទុកដាក់៖** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺ មានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636 (TTY 711)**។

**日本語 (Japanese): 注意事項 :** 無料の日本語での言語サポートをご利用いただけます。 **1-888-901-4636 (TTY 711)** まで、お電話にてご連絡ください。

**አማርኛ (Amharic): ማሳሰቢያ፡** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እገዛ አገልግሎቶች በነጻ ለእርስዎ ይቀርባሉ። ወደ **1-888-901-4636 (TTY 711)** ይደውሉ።

**Oromiffa (Oromo): XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa yoo ta'e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636 (TTY 711)** irraatti bilbilaa.

**ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636 (TTY 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

**العربية (Arabic):** انتباه إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل بالرقم **(TTY 711) 1-888-901-4636**

**Deutsch (German): ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636 (TTY 711)**.

**ພາສາລາວ (Lao): ໄປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636 (TTY 711)**.