


KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852  
 Kaiser Permanente Insurance Company, One Kaiser Plaza, Oakland, CA 94612



**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 <https://kp.org/plandocuments> or call 1-855-249-5018 (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 1-855-249-5018 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>KP <a href="#">Plan Provider</a>: \$1,600 Self only enrollment / \$3,200 for any one member within a Family enrollment / \$3,200 for an entire Family;  <a href="#">Participating Provider</a>: \$3,200 Self only enrollment / \$3,200 for any one member within a Family enrollment / \$5,000 for an entire Family;  <a href="#">Non-Participating Provider</a>: \$4,500 Self only enrollment / \$4,500 for any one member within a Family enrollment / \$9,000 for an entire Family;</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>

Important Questions	Answers	Why this Matters:
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	KP <a href="#">Plan Provider</a> : \$3,400 Self only enrollment / \$3,400 for any one member within a Family enrollment / \$6,800 for an entire Family; <a href="#">Participating Provider</a> : \$4,000 Self only enrollment / \$4,000 for any one member within a Family enrollment / \$8,000 for an entire Family; <a href="#">Non-Participating Provider</a> : \$8,050 Self only enrollment / \$8,050 for any one member within a Family enrollment / \$16,100 for an entire 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , and health care this <a href="#">plan</a> doesn't cover.	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. See <a href="http://www.kp.org">www.kp.org</a> or call 1-855-249-5018 (TTY: 711) for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in the Kaiser Permanente network. You pay more if you use a <a href="#">provider</a> in the <a href="#">participating provider</a> network. 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 provider's 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> ?	Yes (to be covered at the <a href="#">plan provider</a> level), 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 Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	\$10 / visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 / visit	\$30 / visit	20% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Xray: \$20 / visit. Lab tests: No charge.	Xray: \$30 / visit. Lab tests: \$10 / visit.	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRI's)	\$100 / test	\$150 / test	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
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.kp.org/formulary">www.kp.org/formulary</a>	Most generic drugs (Tier 1)	\$10 / <a href="#">prescription</a>	\$20 / <a href="#">prescription</a>	20% <a href="#">coinsurance</a>	Up to a 30-day supply; Up to a 90-day supply for 2 copays. <a href="#">Plan</a> and <a href="#">Participating Provider</a> in all drug tiers: No charge, <a href="#">deductible</a> does not apply for <a href="#">preventive</a> drugs and contraceptives. No charge for oral chemotherapy drugs.
	Most preferred brand name drugs (Tier 2)	\$30 / <a href="#">prescription</a>	\$45 / <a href="#">prescription</a>	20% <a href="#">coinsurance</a>	Up to a 30-day supply; <a href="#">Plan</a> and <a href="#">Participating Provider</a> : Up to a 90-day supply for 2 copays.
	Non-preferred drugs (Tier 3)	\$50 / <a href="#">prescription</a>	\$65 / <a href="#">prescription</a>	20% <a href="#">coinsurance</a>	Up to a 30-day supply; <a href="#">Plan</a> and <a href="#">Participating Provider</a> : Up to a 90-day supply for 2 copays
	<a href="#">Specialty drugs</a> (Tier 4)	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> / <a href="#">prescription</a>	Up to a \$150 max / 30-day supply or up to a \$300 max / 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 / visit	\$150 / visit	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	Physician/surgeon fees	No charge	No charge	20% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 / visit	\$350 / visit, after <a href="#">Plan Provider deductible</a>	\$350 / visit, after <a href="#">Plan Provider deductible</a>	<a href="#">Copayment</a> waived if admitted as inpatient
	<a href="#">Emergency medical transportation</a>	No charge	No charge, after <a href="#">Plan Provider deductible</a>	No charge, after <a href="#">Plan Provider deductible</a>	None
	<a href="#">Urgent care</a>	\$20 / visit	\$30 / visit	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 / admission	\$250 / admission	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	Physician/surgeon fee	No charge	No charge	20% <a href="#">coinsurance</a>	<a href="#">Plan &amp; Participating Providers</a> : Physician / surgeon fees are included in Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$10 / individual visit. \$5 / group visit.	20% <a href="#">coinsurance</a>	None
	Inpatient services	\$200 / admission	\$250 / admission	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	No charge	20% <a href="#">coinsurance</a>	<a href="#">Plan &amp; Participating Providers</a> : Professional services are included in Facility fee.
	Childbirth/delivery facility services	\$200 / admission	\$250 / admission	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	\$100 / year	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	<a href="#">Rehabilitation services</a>	\$20 / visit	\$30 / visit	20% <a href="#">coinsurance</a>	Outpatient: PT/OT/ST limit of 30 visits / therapy / condition / year ( <a href="#">Plan Provider</a> OR <a href="#">Participating &amp; Non-Participating Provider</a> combined). Cardiac Rehab limit to 90 consecutive days / year. <a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000/year.
	<a href="#">Habilitation services</a>	\$20 / visit	\$30 / visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	\$200 / admission	\$250 / admission	20% <a href="#">coinsurance</a>	Coverage is limited to 100 days / year ( <a href="#">Plan Provider</a> OR <a href="#">Participating &amp; Non-Participating Provider</a> combined). <a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000/year.
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Hospice service</a>	No charge	\$100 per	20% <a href="#">coinsurance</a>	<a href="#">Participating &amp; Non-Participating Providers</a> : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Participating Provider (You will pay more)	What You Will Pay Non-participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	\$10 / visit	20% <a href="#">coinsurance</a>	Coverage is limited to one exam / year.
	Children's glasses	No charge	Not covered	40% <a href="#">coinsurance</a>	<a href="#">Plan Provider</a> : 1 pair of glasses / year or 1st purchase of contact lenses / year or 2 pair / eye / year <a href="#">medically necessary</a> contacts (from select group of frames and contacts); <a href="#">Non-Plan Provider</a> : 1 pair / year (non-designer frames)
	Children's dental check-up	No charge, <a href="#">deductible</a> does not apply	Not covered	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	Coverage is limited to members up to the end of the month in which the member turns 19.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (Plan Provider referred)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (20 visits / year, Plan Provider OR Participating &amp; Non-Participating Providers combined)</li> <li>• Hearing aids (One aid / ear / 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</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 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	1-855-249-5018 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</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>
Maryland Insurance Administration	1-877-261-8807 or <a href="http://www.insurance.maryland.gov">www.insurance.maryland.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 1-855-249-5018 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5018 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-855-249-5018 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5018 (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 [plan's](#) overall [deductible](#) \$3,200
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$200
- Other (blood work) [copayment](#) \$0

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>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,460</b>

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$200
- Other (blood work) [copayment](#) \$0

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>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$400
<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 [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$200
- Other (x-ray) [copayment](#) \$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

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



# NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, call **1-888-225-7202** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: KPIC Civil Rights Coordinator, Grievance 1557, Nine Piedmont Center, 3495 Piedmont Road, NE, Atlanta, GA 30305-1736, telephone number 1-888-225-7202.

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, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call **1-888-225-7202** (TTY: **711**).

**አማርኛ (Amharic) ያስተውሉ፡-አንግሊዘኛ የሚናገሩ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ ከከፍተኛ ነጻ፣ ለእርስዎ ይገኛሉ። ወደ **1-888-225-7202** ይደውሉ (TTY: **711**)።**

**العربية (Arabic) ملحوظة :** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-225-7202** (TTY: **711**).

**Bàsò ò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo:** ɔ jũ ké m̀ Bàsòò wùdù po nyò jũ ní, níí, à wuɖu kà kò dò po poò béin m̀ gbo kpáa. **Đá 1-888-225-7202** (TTY: **711**)

**বাংলা (Bengali) মনোযোগ দিন:** যদি আপনি ইংরেজিতে কথা বলেন, আপনার জন্য ভাষা সহায়তা পরিষেবা, বিনামূল্যে উপলব্ধ। **1-888-225-7202** (TTY: **711**) এ কল করুন।

**中文 (Chinese) 注意:** 如果您使用繁體中文，您可以免費獲得語言協助服務。請致電 **1-888-225-7202** (TTY: **711**)

**فارسی (Farsi) توجه:** اگر به زبان فارسی صحبت می‌کنید، خدمات تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با شماره **1-888-225-7202** (TTY: **711**) تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-225-7202** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen eine kostenlose Sprachassistenz zur Verfügung. Bitte wählen Sie: **1-888-225-7202** (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે અંગ્રેજી બોલો છો, તો ભાષા સહાય સેવાઓ, વિના મૂલ્યે, આના પર ઉપલબ્ધ છે તમે. **1-888-225-7202** (TTY: 711) પર કોલ કરો.

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-225-7202** (TTY: 711).

हिंदी (Hindi) ध्यान दें: यदि आप अंग्रेजी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। **1-888-225-7202** (टीटीवाई: 711) पर कॉल करें।

**Igbo (Igbo) GEE NTI:** Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka nkowa asụsụ, du n'efu, dịjiri gị. Kpọọ **1-888-225-7202** (TTY: 711).

**Italiano (Italian) ATTEZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-225-7202** (TTY: 711).

**Iloko (Ilocano) PAKDAAR:** No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-888-238-5742** (TTY: 711)

日本語 (Japanese) 注意事項: 日本語を話される場合、言語支援サービスを無料でご利用いただけます。 **1-888-225-7202** (TTY:711) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-225-7202** (TTY: 711)번으로 전화해 주십시오.

**Naabeehó (Navajo) Díí baa akó nínízin:** Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, koji' hódíílnih **1-888-225-7202** (TTY: 711).

**Português (Portuguese) ATENÇÃO:** Se fala português, encontram se disponíveis de forma gratuita serviços linguísticos. Basta ligar para **1-888-225-7202** (TTY: 711).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните **1-888-225-7202** (TTY: 711).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-225-7202** (TTY: 711).

**Tagalog (Tagalog) PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-225-7202** (TTY: 711).

**ไทย (Thai) โปรดทราบ:** หากคุณพูดภาษาอังกฤษ คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร **1-888-225-7202** (TTY: 711).

اردو (Urdu) خبردار: اگر آپ انگریزی زبان بولتے ہیں، تو لسانی معاونت کی خدمات، بلامعاوضہ، آپ کے لیے دستیاب ہیں۔ **1-888-225-7202** (TTY: 711) پر کال کریں۔

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-225-7202** (TTY: 711).

**Yorùbá (Yoruba) AKIYESI:** Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun o. Pe **1-888-225-7202** (TTY: 711)