



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/ or call 1-855-249-5018 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	KP Plan Provider : \$1,000 Individual / \$2,000 Family; Participating Provider : \$1,500 Individual / \$3,000 Family; Non-Participating Provider : \$4,000 Individual / \$8,000 Family;	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 .
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	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, KP Plan Provider : \$200 / Individual for Brand and Specialty Prescription drugs ; Participating Provider : \$250 / Individual for Brand and Specialty Prescription drugs ; There are no other specific deductibles .	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.
What is the out-of-pocket limit for this plan?	KP Plan Provider : \$4,450 Individual / \$8,900 Family; Participating Provider : \$4,650 Individual / \$9,300 Family; Non-Participating Provider : \$9,100 Individual / \$18,200 Family	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.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Premiums , precertification penalties, balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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. See www.kp.org or call 1-855-249-5018 (TTY: 711) for a list of network providers .	You pay the least if you use a provider in the Kaiser Permanente network. You pay more if you use a provider in the participating provider 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?	Yes (to be covered at the plan provider level), but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit, deductible does not apply	\$35 / visit, deductible does not apply	20% coinsurance	None
	Specialist visit	\$40 / visit, deductible does not apply	\$55 / visit, deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	20% 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.

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 have a test	Diagnostic test (x-ray, blood work)	Xray: \$40 / visit, deductible does not apply. Lab tests: \$25 / visit, deductible does not apply.	Xray: \$60 / visit, deductible does not apply. Lab tests: \$45 / visit, deductible does not apply.	20% coinsurance	None
	Imaging (CT/PET scans, MRI's)	\$350 / test	\$400 / test	20% coinsurance	Participating & Non-Participating Providers : 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 prescription drug coverage is available at www.kp.org/formulary	Most generic drugs (Tier 1)	\$25 / retail, deductible does not apply. \$50 / mail order / prescription , deductible does not apply.	\$45 / prescription , deductible does not apply	20% coinsurance	Up to a 30-day supply (retail & participating pharmacies); up to a 90-day supply (mail order). Plan & Participating Providers : Formulary preventive drugs and contraceptives in all tiers are No charge, deductible does not apply.
	Most preferred brand name drugs (Tier 2)	\$50 / retail. \$100 / mail order / prescription , after drug deductible .	\$80 / prescription , after drug deductible	20% coinsurance	Up to a 30-day supply (retail & participating pharmacies); up to a 90-day supply (mail order).
	Non-preferred drugs (Tier 3)	\$80 / retail. \$160 / mail order / prescription , after drug deductible .	\$100 / prescription , after drug deductible	20% coinsurance	Up to a 30-day supply (retail & participating pharmacies); up to a 90-day supply (mail order).
	Specialty drugs (Tier 4)	50% coinsurance up to \$150 max / prescription , after drug deductible .	50% coinsurance up to \$150 max / prescription , after drug deductible .	50% coinsurance up to \$150 max / prescription .	Up to a 30-day supply (retail & participating pharmacies).

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$275 / visit	\$325 / visit	20% coinsurance	Participating & Non-Participating Providers : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	Physician/surgeon fees	\$40 / visit	\$55 / visit	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$350 / visit	\$350 / visit	\$350 / visit	Covered In- Plan . Copayment waived if admitted as inpatient
	Emergency medical transportation	No charge	No charge	No charge	Covered In- Plan .
	Urgent care	\$40 / visit, deductible does not apply	\$55 / visit, deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$550 / admission	\$600 / admission	20% coinsurance	Participating & Non-Participating Providers : 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% coinsurance	Plan & Participating Providers : Physician / surgeon fees are included in Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / Individual visit, deductible does not apply	\$35 / Individual visit, deductible does not apply	20% coinsurance	Plan Provider : \$10 / Group visit, deductible does not apply; Participating Provider : \$17 / Group visit, deductible does not apply
	Inpatient services	\$550 / admission	\$600 / admission	20% coinsurance	Participating & Non-Participating Providers : 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 are pregnant	Office visits	No charge, deductible does not apply	No charge, deductible does not apply	20% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible 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% coinsurance	Plan & Participating Providers : Professional services are included in Facility fee.
	Childbirth/delivery facility services	\$550 / admission	\$600 / admission	20% coinsurance	Participating & Non-Participating Providers : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
If you need help recovering or have other special health needs	Home health care	No charge	\$100 / visit	20% coinsurance	Participating & Non-Participating Providers : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	Rehabilitation services	\$40 / visit, deductible does not apply	\$60 / visit, deductible does not apply	20% coinsurance	PT/ST/OT limit of 30 visits / therapy /condition / year. Participating and Non-Participating Providers : Precertification required. Failure to pre-certify may result in a penalty of 30% up to \$5,000 / year. Limited to a combined maximum of 30 visits each for PT/OT/ST/year.
	Habilitation services	\$40 / visit, deductible does not apply	\$60 / visit, deductible does not apply	20% coinsurance	Participating & Non-Participating Providers : Precertification required. Failure to precertify may result in a penalty of 30% up to \$5,000 / year.
	Skilled nursing care	\$550 / admission	\$600 / admission	20% coinsurance	Coverage is limited to Plan Provider : maximum 100 days/year; Participating and Non-Participating Providers : Precertification required. Failure to precertify may results in a penalty of 30% up to \$5000/year. Combined maximum of 100 days/year.
	Durable medical equipment	No charge	20% coinsurance	40% coinsurance	Subject to formulary guidelines
	Hospice service	No charge	\$100 / admission	20% coinsurance	Participating & Non-Participating Providers : 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 your child needs dental or eye care	Children's eye exam	\$20 / visit for refractive exam, deductible does not apply	\$30 / visit for refractive exam, deductible does not apply	20% coinsurance	Coverage is limited to one exam / year.
	Children's glasses	No charge	Not covered	40% coinsurance	Plan and Non-Participating Providers : 1 pair of glasses or contact lenses / year (from select group of glasses / contacts) each.
	Children's dental check-up	No charge, deductible does not apply	Not covered	20% coinsurance	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 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"> • Cosmetic surgery • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine Foot Care • Weight loss programs

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"> • Acupuncture (Provider referred) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care (20 visits / year, Plan Provider OR Participating & Non-Participating Providers combined) • Hearing aids (1 aid / ear / 36 months) 	<ul style="list-style-type: none"> • Infertility treatment • Routine eye care (Adult)

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 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 www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Maryland Insurance Administration	1-877-261-8807 or www.insurance.maryland.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](#).

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)

TRADITIONAL 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)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-249-5018 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5018 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5018 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut allillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5018 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 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](#) \$1,000
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$550
- Other (blood work) [copayment](#) \$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*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,660

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
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$550
- Other (blood work) [copayment](#) \$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*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$700

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$550
- Other (x-ray) [copayment](#) \$40

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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>.

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**).

Básó 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 ị. Kpọọ **1-888-225-7202** (TTY: 711).

Italiano (Italian) ATTENZIONE: 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 **1-888-225-7202** (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 hól'ó, koj'í' 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).

اُردو (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)