


All [plans](#) offered and underwritten by Kaiser Foundation Health [Plan](#) of the Northwest



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 1-800-813-2000 (TTY: 711). For 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 <http://www.healthcare.gov/sbc-glossary> or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$7,000 Individual / \$14,000 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>	\$9,450 Individual / \$18,900 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 1-800-813-2000 (TTY: 711) for a list of <a href="#">In-Network Providers</a> .	You pay the least if you use a <a href="#">provider</a> in the <a href="#">In-Network Provider</a> tier. You pay more if you use a <a href="#">provider</a> in the <a href="#">Out-of-Network Provider</a> tier. 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> ).
<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
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	First 3 visits: \$5 / visit, <a href="#">deductible</a> does not apply. Additional visits: \$60 / visit, <a href="#">deductible</a> does not apply.	\$80 / visit, <a href="#">deductible</a> does not apply.	The first 3 visits can be any combination of primary care, mental/behavioral health, substance abuse services, and other qualified visits. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	<a href="#">Specialist</a> visit	\$80 / visit	\$100 / visit, <a href="#">deductible</a> does not apply.	<a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	<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.	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. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 40% <a href="#">coinsurance</a> Lab tests: 40% <a href="#">coinsurance</a>	X-ray: 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply. Lab tests: 50% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	<a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	Some services may require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	\$30 (retail); \$60 (mail order) / prescription, <a href="#">deductible</a> does not apply.	\$50 (retail) / prescription, <a href="#">deductible</a> does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. <b>Out-of-Network Provider:</b> Limited to a combined maximum of 5 prescription fills / year.
	Preferred brand drugs	\$100 (retail); \$200 (mail order) / prescription, <a href="#">deductible</a> does not apply.	\$120 (retail) / prescription, <a href="#">deductible</a> does not apply.	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. <b>Out-of-Network Provider:</b> Limited to a combined maximum of 5 prescription fills / year.
	Non-preferred brand drugs	50% <a href="#">coinsurance</a> (retail & mail order)	50% <a href="#">coinsurance</a> (retail), <a href="#">deductible</a> does not apply.	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 exception process. Must be authorized through the non-preferred drug process. <b>Out-of-Network Provider:</b> Limited to a combined maximum of 5 prescription fills / year.
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> (retail)	50% <a href="#">coinsurance</a> (retail), <a href="#">deductible</a> does not apply.	Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through exception process. <b>Out-of-Network Provider:</b> Limited to a combined maximum of 5 prescription fills / year.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<b>Out-of-Network Provider:</b> only covered if you are out of the service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	First 3 visits: \$5 / visit, <a href="#">deductible</a> does not apply. Additional visits: \$60 / visit, <a href="#">deductible</a> does not apply.	\$80 / visit, <a href="#">deductible</a> does not apply.	The first 3 visits can be any combination of primary care, mental/behavioral health, substance abuse services, and other qualified visits. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.
<b>If you are pregnant</b>	Office visits	No charge, <a href="#">deductible</a> does not apply.	No charge, <a href="#">deductible</a> does not apply.	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). <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	Prior authorization required.
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	None
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Rehabilitation services</a>	Outpatient: \$80 / visit Inpatient: 40% <a href="#">coinsurance</a>	Outpatient: \$100 / visit, <a href="#">deductible</a> does not apply. Inpatient: Not covered	Outpatient: 30 visit limit / year. Prior authorization required. Inpatient: Prior authorization required. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	<a href="#">Habilitation services</a>	\$80 / visit	\$100 / visit, <a href="#">deductible</a> does not apply.	30 visit limit / year. Prior authorization required. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	60 day limit / year. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">formulary</a> guidelines. Prior authorization required.
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply.	Not covered	Prior authorization required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge for refractive exam, <a href="#">deductible</a> does not apply.	\$80 / visit for refractive exam, <a href="#">deductible</a> does not apply.	Limited to 1 exam / year. <a href="#">Out-of-Network Provider</a> : Limited to certain benefits, up to a combined maximum of 10 visits and/or services / year.
	Children's glasses	No charge, <a href="#">deductible</a> does not apply	Not covered	Limited to one pair of select frames and lenses or six month supply contact lenses / 1 calendar year.
	Children's dental checkups	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
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- 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.)**

- Acupuncture (12 visit limit / year)
- Chiropractic (20 visit limit / year)
- Hearing aids (1 aid / ear, every 36 months)
- 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](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.

Kaiser Permanente Member Services	1-800-813-2000 (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>
Oregon Division of Financial Regulation	1-888-877-4894 or <a href="http://www.dfr.oregon.gov">www.dfr.oregon.gov</a>

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

**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 1-800-813-2000 (TTY: 711).

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711).

[Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-813-2000 (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>	\$7,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other (blood work) <a href="#">coinsurance</a>	40%

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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$7,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,170</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>	\$7,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other (blood work) <a href="#">coinsurance</a>	40%

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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,600</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>	\$7,000
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other (x-ray) <a href="#">coinsurance</a>	40%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,810</b>



## **Nondiscrimination Notice**

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239**.

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 2020, Phone: 1-800-368-1019, TDD: 1-800-537-7697. Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

### **For Washington Members**

You can also file a complaint with 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 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.



## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-800-813-2000 (TTY: 711).

**አማርኛ (Amharic) ማሳሰቢያ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገዳ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-813-2000 (TTY: 711)።

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-813-2000 (TTY: 711).

**中文 (Chinese) 注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-813-2000 (TTY: 711)。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-813-2000 (TTY: 711) تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-813-2000 (TTY: 711).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-813-2000 (TTY: 711).

**日本語 (Japanese) 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-813-2000 (TTY: 711) まで、お電話にてご連絡ください。

**ខ្មែរ (Khmer) ប្រយោជន៍:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-800-813-2000 (TTY: 711)។

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-813-2000 (TTY: 711) 번으로 전화해 주십시오.

**ລາວ (Laotian) ໄປອຊາບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-800-813-2000 (TTY: 711).

**Afaan Oromoo (Oromo) XIYYEEFFANNA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-813-2000 (TTY: 711).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-813-2000 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**Română (Romanian) ATENȚIE:** Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-813-2000 (TTY: 711).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-813-2000 (TTY: 711).

**Español (Spanish) ATENCION:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-813-2000 (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 1-800-813-2000 (TTY: 711).

**ไทย (Thai) เรียน:** ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-813-2000 (TTY: 711).

**Українська (Ukrainian) УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-813-2000 (TTY: 711).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-813-2000 (TTY: 711).