




: [KPLF 3000 / 20% / 6000](#)

Coverage for: Individual / Family | [Plan](#) Type: Ded EPO



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 <http://GeorgiaLevelFunded.kp.org> or call 1-800-401-8405 (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 1-800-401-8405 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$3,000 Individual / \$6,000 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 the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> and services indicated in chart beginning 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> .
<a href="#">Are there other deductibles for specific services?</a>	No	You don't have to meet <a href="#">deductibles</a> for specific services
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$6,000 Individual / \$12,000 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart beginning on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-401-8405 (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.
<a href="#">Do you need a referral to see a specialist?</a>	Yes, but you may self-refer to some <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
		<a href="#">Plan Provider</a> (You will pay the least)	<a href="#">Non-Plan Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$40 / visit, <a href="#">deductible</a> does not apply	Not covered	Virtual care services: No charge, <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$60 / visit, <a href="#">deductible</a> does not apply	Not covered	Virtual care services: No charge, <a href="#">deductible</a> does not apply.
	<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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge, <a href="#">deductible</a> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.kp.org/formulary">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	\$15 / <a href="#">prescription</a> (retail); \$25 / <a href="#">prescription</a> ( <a href="#">network pharmacies</a> ); and \$30 mail order / <a href="#">prescription, deductible</a> does not apply	Not covered	\$5 / <a href="#">prescription</a> (retail); \$10 / <a href="#">prescription</a> (mail order) for generic maintenance medications, <a href="#">deductible</a> does not apply ( <a href="#">Plan Provider pharmacies</a> ). Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail), up to a 90-day supply (mail order). <a href="#">Network Pharmacies</a> limited to a one-time fill. No charge for contraceptives, <a href="#">deductible</a> does not apply.
	Preferred brand drugs	\$50 / <a href="#">prescription</a> (retail); \$70 / <a href="#">prescription</a> ( <a href="#">network pharmacies</a> ); and \$100 mail order / <a href="#">prescription, deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail), up to a 90-day supply (mail order). <a href="#">Network Pharmacies</a> limited to a one-time fill.
	Non-preferred brand drugs	\$80 / <a href="#">prescription</a> (retail); \$110 / <a href="#">prescription</a> ( <a href="#">network pharmacies</a> ); and \$160 mail order / <a href="#">prescription, deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail), up to a 90-day supply (mail order). <a href="#">Network Pharmacies</a> limited to a one-time fill.
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> up to a \$300 maximum (retail); 20% <a href="#">coinsurance</a> ( <a href="#">network pharmacies</a> ), <a href="#">deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail). <a href="#">Network Pharmacies</a> limited to a one-time fill.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 / visit, <a href="#">deductible</a> does not apply	\$500 / visit, <a href="#">deductible</a> does not apply	<a href="#">Copayment</a> waived if admitted directly to the hospital as an inpatient.
	<a href="#">Emergency medical transportation</a>	\$500 / trip, <a href="#">deductible</a> does not apply	\$500 / trip, <a href="#">deductible</a> does not apply	None
	<a href="#">Urgent care</a>	\$80 / visit, <a href="#">deductible</a> does not apply	Not covered	<a href="#">Non-Plan Providers</a> covered when temporarily outside of the service area at \$80 / visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<a href="#">Plan Provider</a> (You will pay the least)	<a href="#">Non-Plan Provider</a> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 / individual visit, <a href="#">deductible</a> does not apply	Not covered	\$20 / group visit, <a href="#">deductible</a> does not apply. Virtual care services: No charge, <a href="#">deductible</a> does not apply.
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	None
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	None
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	Limited to 120 days / year
	<a href="#">Rehabilitation services</a>	Outpatient: \$60 / visit, <a href="#">deductible</a> does not apply. Inpatient: 20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 40 visits / year combined for occupational and physical therapies, speech therapy 40 visits / year.
	<a href="#">Habilitation services</a>	\$60 / visit, <a href="#">deductible</a> does not apply.	Not covered	Coverage is limited to 40 visits / year combined for occupational and physical therapies, speech therapy 40 visits / year.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Limited to 150 days / year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	Coverage is limited to items on our <a href="#">DME formulary</a> .
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$40 / visit, <u>deductible</u> does not apply	Not covered	None
	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Children's glasses</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult &amp; child)</li> <li>Hearing aids</li> <li>Infertility treatment</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> <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 <u>plan</u> document.)
<ul style="list-style-type: none"> <li>Chiropractic care (20 visit / year)</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	1-800-788-0710
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.ebsa/healthreform">www.dol.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>

**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 1-800-401-8405 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-401-8405 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-401-8405 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-401-8405 (TTY: 711)

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

Your health benefits will be self-insured by your [Plan](#) Sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the [Plan](#) and will not be an insurer of the [Plan](#) or financially liable for health care benefits under the [Plan](#).

## 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](#) \$3,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- 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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,770</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- 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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other (x-ray) [copayment](#) \$0

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>	\$300
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
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 federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. 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: **1-866-213-3062** (TTY: **711**)

If you believe that KPIC 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, 3701 Boardman-Canfield Rd, Canfield OH 44406, telephone number 1-866-213-3062.

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 **1-866-213-3062** (TTY: **711**).

**አማርኛ (Amharic) ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-866-213-3062** (TTY: **711**).

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-213-3062** (TTY: **711**).

**Հայերեն (Armenian):** Ուժեղագույնը թույլ է տալիս անհատներին, որոնք խոսում են հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք **1-866-213-3062** (TTY **711**):

**Bàsóò Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo:** ɔ jũ ké m̀ Bàsóò-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò b̀éìn m̀ gbo kpáa. Đá **1-866-213-3062** (TTY: 711)

**বাংলা (Bengali) লক্ষ্য করুন:** যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711)。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-213-3062** تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-213-3062** (TTY: 711).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-213-3062** (TTY: 711).

**ગુજરાતી (Gujarati) સુચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-866-213-3062** (TTY: 711).

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-213-3062** (TTY: 711).

**हिन्दी (Hindi) ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-866-213-3062** (TTY: 711) पर कॉल करें।

**Hmoob (Hmong) CEEB TOOM:** Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, uas pab dawb rau koj. Hu rau **1-866-213-3062** (TTY: 711).

**Igbo (Igbo) NRUBAMA:** Ọ bụrụ na ị na asụ Igbo, orụ enyemaka asụsụ, n'efu, dijirị gi. Kpọọ **1-866-213-3062** (TTY: 711).

**Italiano (Italian) ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-213-3062** (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。 **1-866-213-3062** (TTY: 711) まで、お電話にてご連絡ください。

**ខ្មែរ (Khmer) ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-866-213-3062** (TTY: 711)។

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-213-3062** (TTY: 711) 번으로 전화해 주십시오.

**ລາວ (Laotian) ໄປດຊາບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-866-213-3062** (TTY: 711).

**Naabeehó (Navajo) Díí baa akó nínízin:** Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jii'eh, éí ná hóló, koji' hódíílnih **1-866-213-3062** (TTY: 711).

**नेपाली (Nepali) ध्यान दिनुहोस्:** तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । **1-866-213-3062** (TTY: 711) फोन गर्नुहोस् ।

**Afaan Oromoo (Oromo) XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-866-213-3062** (TTY: 711).

**Português (Portuguese) ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-213-3062** (TTY: 711).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-866-213-3062** (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**Română (Romanian) ATENȚIE:** Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-866-213-3062** (TTY: 711).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-213-3062** (TTY: 711).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711).

**ไทย (Thai) เรียน:** ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-866-213-3062** (TTY: 711).

**Українська (Ukrainian) УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-866-213-3062** (TTY: 711).

**اردو (Urdu) خبردار:** اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711).

**Yorùbá (Yoruba) AKIYESI:** Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-866-213-3062** (TTY: 711).