



cis benefits
www.cisbenefits.org



KAISER PERMANENTE®

Deductible: Alternative Care & Vision	
January 1, 2025 - December 31, 2025	
Deductible	
For one Member per Calendar Year	\$250
For an entire Family per Calendar Year	\$750
Out-of-Pocket Maximum (Note: All Deductible, Copayment, and Coinsurance amounts count toward the Out of Pocket Maximum, unless otherwise noted.)	
For one Member	\$2,000
For an entire Family	\$6,000
Office visits	
	You pay
Routine preventative physical exam	\$0
Telehealth (phone/video)	\$0*
Primary Care	\$5 for first 3 visits; then \$15 for additional visits in the same Year *
Specialty Care	\$25
Urgent Care	\$35
Tests (outpatient)	
	You pay
Preventive Tests	\$0
Laboratory	\$15 per department visit
X-ray, imaging, and special diagnostic procedures	\$15 per department visit
CT, MRI, PET scans	\$15 per department visit
Medications (outpatient)	
	You pay
Prescription drugs (up to a 30 day supply)	Generic \$10, Preferred \$20, Non-preferred \$20, Specialty \$20 (Per prescription)
Mail Order Prescription drugs (up to a 90 day supply)	2 x Copay
Administered medications, including injections (all outpatient settings)	\$0
Nurse treatment room visits to receive injections	\$10
Maternity Care	
	You pay
Scheduled prenatal care visits and postpartum visits	\$0
Laboratory	\$15 per department visit
X-ray, imaging, and special diagnostic procedures	\$15 per department visit
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	
	You pay
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency services	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	
	You pay
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	\$25 after Deductible
Durable medical equipment	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	\$25
Skilled Nursing Facility Services	
	You pay
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services	
	You pay
Outpatient Services (Group visit ½ copay)	\$5 for first 3 visits; then \$15 for additional visits in the same Year *
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care** (self-referred)	
	You pay

Acupuncture Services (up to 12 visits per year)	\$20 per visit
Chiropractic Services (up to 20 visits per year)	\$20 per visit
Massage Therapy (up to 12 visits per year)	\$25 per visit
Naturopathic Medicine	\$5 for first 3 visits; then \$15 for additional visits in the same Year *
Vision Services	You pay
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	\$0
Vision hardware and optical Services (covered until the end of the month in which the Member turns 19 years of age.)**	No charge for eyeglass lenses or frames or contact lenses every 12 months.
Routine eye exam (For members 19 years and older)	\$15
Vision hardware and optical Services (For members 19 years and older)*	Balance after \$150 allowance, once every calendar year

* First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.

** Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

kp.org Resources:

Here are some ways to make managing your care easier:

Sign on to our convenient online services and stay on top of your treatment from the comfort of your home.

- Find or switch doctors
- View lab test results
- Health risk assessments
- Order prescription refills
- Schedule and cancel appointments
- Exchange secure emails with your doctor and health care team
- Find locations of our medical centers and offices

Appointment Alternatives:

-Advice Nurse Line - If you have a health concern but aren't sure where to go for care, call the Kaiser Permanente advice nurse line at (800) 813-2000. Available 24 hours a day, our advice nurses can give you guidance on getting the care you need, view your medical record, and help schedule an appointment if needed.

-Virtual Care - Virtual care options are available for many health concerns. You can skip a copay and schedule a visit to see a doctor using your computer or mobile device. Call (800) 813-2000 (toll free), (503) 813-2000, or 711 (TTY for the hearing/speech impaired). You can use online scheduling to make an appointment with our Urgent Care providers. We offer both same-day Urgent Care Telephone Appointments and Urgent Care Video Visits.

-Email Your Doctor - You can send a secure email to your doctor and care team for answers to non-urgent health and wellness questions at any time by logging on to kp.org on your computer or mobile device.

Disease Management:

Our integrated health care delivery system provides comprehensive and coordinated care for our members with chronic conditions. All members who are identified by specified criteria are automatically enrolled in one of our disease management programs. Your personal physician, specialists, pharmacists, nurses, nutritionists, class instructors, and others will care for the whole you, body and mind.

Healthy Lifestyle Programs: kp.org/healthylifestyles or kphealthy lifestyles.org:

Digital and telephonic health coaching programs are available at no cost to members. These personalized interactive programs can help a member's goals to lose weight, eat better, manage stress, quit smoking, and more.

The online healthy lifestyle programs include:

- **Balance®** - A weight management program
- **Breathe®** - A program to help you quit smoking ([kp.org/quit smoking](http://kp.org/quit-smoking))
- **Care® for Your Back** – Delivers personalized strategies for preventing and managing back pain
- **Care® for Diabetes** – Tools for managing Diabetes
- **Care for Pain®** - For members living with chronic pain
- **Care® for Depression** – Help with managing depression
- **Care® for sleep** – Tools for sleeping better
- **Relax®** - Stress management

Member Discounts: kp.org/choosehealthy

Available to you at no cost through your health plan, ChooseHealthy™ offers a directory of complementary care providers, an online store, fitness club discounts, savings on health products and services, and more. You'll find reduced rates on:

- Fitness facility memberships
- Chiropractic care
- Health & fitness books & videos
- Massage therapy services
- Acupuncture
- Herbs, vitamins, and supplements


Plan is subject to exclusions and limitations. A complete list of the exclusions and limitations is included in the Evidence of Coverage (EOC). EOCs are available upon request or you may go to kp.org/plandocuments.

Questions? Call Member Services (M-F, 8 am-6 pm) or visit kp.org Portland area: 503-813-2000

All other areas: 1-800-813-2000 TTY.711. Language Interpretation Services, all areas 1-800-324-8010


This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your EOC or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

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 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:
What is the overall deductible ?	\$250 Individual / \$750 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,000 Individual / \$6,000 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.
What is not included in the out-of-pocket limit ?	Premiums , 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 1-800-813-2000 (TTY: 711) for a list of participating providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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, 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 .
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 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
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 / visit, deductible does not apply.	Not covered	\$5 / visit, deductible does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Specialist visit	\$25 / visit, deductible does not apply.	Not covered	None
	Preventive care/screening/immunization	No charge, deductible does not apply.	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$15 / visit, deductible does not apply. Lab tests: \$15 / visit, deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$15 / visit, deductible does not apply.	Not covered	Some services may require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	\$10 (retail); \$20 (mail order) / prescription, deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$20 (retail); \$40 (mail order) / prescription, deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred brand drugs	Applicable Generic or Preferred brand drug cost shares apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Specialty drugs	Applicable Generic or Preferred brand drug cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$35 / visit, deductible does not apply.	Not covered	Non-participating providers covered when temporarily outside the service area: \$35 / visit, deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit, deductible does not apply.	Not covered	\$5 / visit, deductible does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	20% coinsurance	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge, deductible does not apply.	Not covered	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	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
	Home health care	20% coinsurance	Not covered	130 visit limit / year. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special needs	Rehabilitation services	Outpatient: \$25 / visit, deductible does not apply. Inpatient: 20% coinsurance	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	\$25 / visit, deductible does not apply.	Not covered	20 visit limit / therapy / year. Prior authorization required.
	Skilled nursing care	20% coinsurance	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice services	No charge, deductible does not apply.	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, deductible does not apply.	Not covered	None
	Children's glasses	No charge, deductible does not apply	Not covered	Limited to one pair of select frames and lenses or contact lenses / 12 months.
	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](#).)

- Cosmetic surgery
- Dental care (Adult and Child)
- 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)
- Bariatric surgery
- Chiropractic care (20 visit limit / year)
- Hearing aids (dependents under age 26: 1 aid / ear, every 36 months)
- 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.

Kaiser Permanente Member Services	1-800-813-2000 (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
Oregon Division of Financial Regulation	1-888-877-4894 or www.dfr.oregon.gov
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-813-2000 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala’au mai i le numera telefoni 1-800-813-2000 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á’gang 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 plan's overall deductible	\$250
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other (blood work) copayment	\$15

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,010

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other (blood work) copayment	\$15

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$70
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$770

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other (x-ray) copayment	\$15

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$750

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.

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 ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-813-2000 (TTY: 711)።

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

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 (711 : TTY) 1-800-813-2000 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, សេវាជំនួយផ្នែកភាសា 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) ໂປດລາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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).