



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.** Please read the FEHB Plan brochure (RI 73-889) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-800-278-3296 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$ 0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$ 2,000 / person up to \$ 4,000 / family	The <u>out-of-pocket limit</u> , or catastrophic maximum, 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and other services outlined in the FEHB brochure.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org/feds or call 1-800-278-3296 (TTY: 711) for a list of <u>plan providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> 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		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	None
	<u>Specialist</u> visit	\$25 / visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary	Generic drugs	\$10 retail; \$20 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). No charge for contraceptives. Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	\$40 retail; \$80 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred brand drugs	\$40 retail; \$80 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Must be authorized through the exception drug process.
	<u>Specialty drugs</u>	\$100 / <u>prescription</u>	Not covered	Up to 30-day supply. Subject to <u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 / procedure	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	\$100 / visit	\$100 / visit	<u>Copayment</u> waived if admitted directly to hospital as inpatient.
	<u>Emergency medical transportation</u>	\$50 / trip	\$50 / trip	None
	<u>Urgent care</u>	\$15 / visit	\$15 / visit	<u>Non-Plan providers</u> covered when temporarily outside the service area.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: \$15 / individual visit. Substance Abuse: \$15 / individual visit.	Not covered	Mental / Behavioral health: \$7 / group visit; Substance Abuse: \$5 / group visit
	Inpatient services	\$250 / admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in Facility fee	Not covered	None
	Childbirth/delivery facility services	\$250 / admission	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$15 / visit; Inpatient: \$250 / admission	Not covered	None
	<u>Habilitation services</u>	Outpatient: \$15 / visit; Inpatient: \$250 / admission	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	Up to 100 day limit / benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Prior authorization required
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	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 Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic surgery	• Eye glasses	• Private-duty nursing
• Dental care	• Long-term care	• Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
• Acupuncture (plan provider referred)	• Hearing aid (\$1,000 limit / ear every 36 months)	• Routine eye care
• Bariatric surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Chiropractic care (20 visit limit/year)	See the FEHB Plan Brochure for information	
• Infertility treatment		

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-278-3296 (TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: 1-800-278-3296 (TTY: 711).

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 1-800-788-0616 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$350

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$310



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Important Questions	Answers	Why This Matters:
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Are there services covered before you meet your <u>deductible</u> ?	Not applicable	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$ 3,000 / person up to \$ 6,000 / family	The <u>out-of-pocket limit</u> , or catastrophic maximum, 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover, and other services outlined in the FEHB brochure.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.kp.org/feds or call 1-800-278-3296 (TTY: 711) for a list of <u>plan providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> 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		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 / visit	Not covered	None
	<u>Specialist</u> visit	\$40 / visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50 / procedure	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary	Generic drugs	\$15 retail; \$30 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). No charge for contraceptives. Subject to <u>formulary</u> guidelines.
	Preferred brand drugs	\$50 retail; \$100 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Subject to <u>formulary</u> guidelines.
	Non-preferred brand drugs	\$50 retail; \$100 mail order / <u>prescription</u>	Not covered	Up to 30-day supply (retail) and 100-day supply (mail order). Must be authorized through the exception drug process.
	<u>Specialty drugs</u>	\$150 / <u>prescription</u>	Not covered	Up to 30-day supply. Subject to <u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 / procedure	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	\$150 / visit	\$150 / visit	<u>Copayment</u> waived if admitted directly to hospital as inpatient.
	<u>Emergency medical transportation</u>	\$150 / trip	\$150 / trip	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
	<u>Urgent care</u>	\$30 / visit	\$30 / visit	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / admission	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: \$30 / individual visit. Substance Abuse: \$30 / individual visit.	Not covered	Mental / Behavioral health: \$15 / group visit; Substance Abuse: \$5 / group visit
	Inpatient services	\$500 / admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Included in Facility fee	Not covered	None
	Childbirth/delivery facility services	\$500 / admission	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$30 / visit; Inpatient: \$500 / admission	Not covered	None
	<u>Habilitation services</u>	Outpatient: \$30 / visit; Inpatient: \$500 / admission	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	Up to 100 day limit / benefit period.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	Prior authorization required
	<u>Hospice services</u>	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most, plus you may be balance billed)	
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	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 Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Eye glasses • Long-term care 	<ul style="list-style-type: none"> • Private-duty nursing • Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery • Chiropractic care (20 visit limit/year) 	<ul style="list-style-type: none"> • Infertility treatment • Hearing aid (\$1,000 limit / ear every 36 months) • Non-emergency care when traveling outside the U.S. See the FEHB Plan Brochure for information 	<ul style="list-style-type: none"> • Routine eye care • Routine foot care

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Does this plan meet the Minimum Value Standards? Yes

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Language Access Services:

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (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:



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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayments</u>	\$40
■ Hospital (facility) <u>copayments</u>	\$500
■ Other <u>copayments</u>	\$10

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$650

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayments</u>	\$40
■ Hospital (facility) <u>copayments</u>	\$500
■ Other <u>copayments</u>	\$10

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$ 1,200
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$ 1,500

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayments</u>	\$40
■ Hospital (facility) <u>copayments</u>	\$500
■ Other <u>copayments</u>	\$10

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$520

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم (711).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانه روز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کفایت در 24 ساعت شبانه روز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkw pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오(공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງແຕ່ໂທຫາ ພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Navajo: Saad bee áká'a'ayeed náhólq t'áá jiik'é, naadiin doo bibaa' dji' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejji. Atah halne'é áká'adoolwohígíí jókí, t'áadoo le'é t'áá hóhazaadjí hadilyaa'go, éí doodaii' nááná lá al'aa ádaat'ehígíí bee hádadilyaa'go. Kojí hodiilnih **1-800-464-4000**, naadiin doo bibaa' dji' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejji (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojí hodiilnih **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ **711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.