



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 73-012) 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/wa-core, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$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 deductible?	Not Applicable.	This <u>plan</u> 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 deductibles 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 <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	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/wa or call 1-888-4636 (TTY: 711) for a list of <u>network 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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of <u>specialist providers</u> .	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 <u>referral</u> before you see the <u>specialist</u> .





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
		Network Provider (You will pay the least)	Out-of-Network 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	\$25 / visit	Not covered	None
	<u>Specialist</u> visit	\$25 / visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. 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	<u>Preauthorization</u> required or will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/wa	Formulary generic drugs	\$20 (retail); \$40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	\$40 (retail); \$80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	\$60 (retail); \$120 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	<u>Specialty drugs</u>	Preferred: 25% <u>coinsurance</u> up to \$200 (retail) / prescription Non-preferred: 50% <u>coinsurance</u> up to \$500 (retail) / prescription	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 / visit	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 / visit	\$100 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a <u>Non-network provider</u> ; limited to initial emergency only. <u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 / visit	\$100 / visit	<u>Non-Network providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 / admission	Not covered	<u>Preauthorization</u> required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / visit Nothing for group therapy	Not covered	None
	Inpatient services	\$350 / admission	Not covered	<u>Preauthorization</u> required or will not be covered.
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	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
	Childbirth/delivery facility services	\$350 / admission	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
				medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	<u>Preauthorization</u> required or will not be covered.
	<u>Rehabilitation services</u>	Outpatient: \$25 / visit Inpatient: \$350 / admission	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$25 / visit Inpatient: \$350 / admission	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	No charge	Not covered	100-day limit / year. <u>Preauthorization</u> required or will not be covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered.
	<u>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> required or will not be covered.
	If your child needs dental or eye care	Children's eye exam	No charge	Not covered
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 FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Children's glasses Cosmetic surgery Dental Care (Adult and child) 	<ul style="list-style-type: none"> Hearing aids Long-term care 	<ul style="list-style-type: none"> Private duty nursing Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)

- Acupuncture (8 visit limits / year)
- Bariatric surgery
- Chiropractic care (20 visit limits / year)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See FEHB Plan Brochure for information
- Routine eye care
- Routine foot care

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 (RI 73-012) 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 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: Kaiser Foundation Health Plan of Washington Member Appeal Department at 1-866-458-5479

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 1-888-901-4636.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636.

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 \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$350
- 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*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
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The total Peg would pay is \$420

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$350
- 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*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Joe would pay is \$1,100

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$350
- 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*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$500



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Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$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 deductible?	Not Applicable.	This <u>plan</u> 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 deductibles 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> ?	\$5,000 per person or per 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 <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	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/wa or call 1-888-4636 (TTY: 711) for a list of <u>network 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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of <u>specialist</u> providers.	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 <u>referral</u> before you see the <u>specialist</u> .



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
		Network Provider (You will pay the least)	Out-of-Network 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	\$25 / visit	Not covered	No primary care <u>copayment</u> for children through age 17.
	<u>Specialist</u> visit	\$35 / visit	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. 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)	\$100 / visit	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/wa	Formulary generic drugs	Preventive: \$5 (retail); \$10 (mail order) / prescription. \$20 (retail); \$40 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	\$40 (retail); \$80 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	\$60 (retail); \$120 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	<u>Specialty drugs</u>	Preferred: 25% <u>coinsurance</u> up to \$200 (retail) / prescription Non-preferred: 50% <u>coinsurance</u> up to \$500 (retail) / prescription	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 / visit	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a <u>Non-network provider</u> ; limited to initial emergency only. <u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	\$100 / trip	\$100 / trip	None
	<u>Urgent care</u>	\$25 / primary care visit; \$35 / specialty care visit	\$150 / visit	<u>Non-Network providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 / admission	Not covered	<u>Preauthorization</u> required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 / visit; Nothing for group therapy	Not covered	None
	Inpatient services	\$750 / admission	Not covered	<u>Preauthorization</u> required or will not be covered.
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	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
	Childbirth/delivery facility services	\$750 / admission	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$25 / visit	Not covered	<u>Preauthorization</u> required or will not be covered.
	<u>Rehabilitation services</u>	Outpatient: \$25 / primary care visit; \$35 / specialty care visit Inpatient: \$750 / admission	Not covered	No primary care <u>copayment</u> for children through age 17. Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$25 / primary care visit; \$35 / specialty care visit Inpatient: \$750 / admission	Not covered	No primary care <u>copayment</u> for children through age 17. Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	No charge	Not covered	100-day limit / year. <u>Preauthorization</u> required or will not be covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered.
	<u>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> required or will not be covered.
	If your child needs dental or eye care	Children's eye exam	No charge	Not covered
Children's glasses		Not covered	Not covered	
Children's dental check-up		Not covered	Not covered	

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> .)		
<ul style="list-style-type: none">• Children's glasses• Cosmetic surgery• Dental Care (Adult and child)	<ul style="list-style-type: none">• Hearing aids• Long-term care	<ul style="list-style-type: none">• Private duty nursing• Weight loss programs
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 (8 visit limit / year)• Bariatric surgery• Chiropractic care (20 visit limit / year)	<ul style="list-style-type: none">• Infertility treatment• 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

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 (RI 73-012) 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 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.

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Does this plan meet the Minimum Value Standards? Yes

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636

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 \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$750
- 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*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$820

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$750
- 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*)

Total Example Cost \$5,600

In this example, Joe would pay:

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

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

- The plan's overall deductible \$0
- Specialist copayment \$35
- Hospital (facility) copayment \$750
- 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*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$460



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 73-012) 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/wa-core, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-888-901-4636 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 / person up to \$500 / family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. <u>Copayments</u> and <u>coinsurance</u> amounts do not count toward your <u>deductible</u> , which generally starts over January 1. When a covered service/supply is subject to a <u>deductible</u> , only the <u>Plan</u> allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and services indicated in chart starting on page 2.	This <u>plan</u> 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$6,000 / person up to \$12,000 / 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 <u>plan</u> , 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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and services indicated in chart starting on page 2.	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/wa or call 1-888-901-4636 (TTY: 711) for a list of <u>network 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. See www.kp.org/wa or call 1-888-901-4636 (TTY: 711) for a list of <u>specialist</u> providers.	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 <u>referral</u> before you see the <u>specialist</u> .



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	Deductible applies to procedures received during an office visit.
	<u>Specialist</u> visit	\$40 / visit	Not covered	Deductible applies to procedures received during an office visit.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	Services must be in accordance with the Kaiser Permanente well-care schedule. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab services: No charge X-ray services: \$50 / visit; <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$150 / visit; <u>deductible</u> does not apply	Not covered	<u>Preauthorization</u> required or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/wa	Formulary generic drugs	Preventive: \$5 (retail); \$10 (mail order) / prescription \$20 (retail); \$40 (mail order) / prescription; <u>deductible</u> does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Formulary brand drugs	\$60 (retail); \$120 (mail order) / prescription; <u>deductible</u> does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	Non-formulary drugs	\$100 (retail); \$200 (mail order) / prescription; <u>deductible</u> does not apply	Not covered	Up to a 30-day supply (retail); up to 90-day supply (mail order)
	<u>Specialty drugs</u>	Preferred: 35% <u>coinsurance</u> up to \$300 (retail) / prescription Non-preferred: 50% <u>coinsurance</u> up to \$500 (retail) / prescription; <u>deductible</u> does not apply	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / visit	Not covered	None
	Physician/surgeon fees	Included in facility fee	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 / visit	\$200 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a <u>Non-network provider</u> ; limited to initial emergency only. <u>Copayment</u> waived if admitted directly to the hospital as an inpatient.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$15 / primary care visit; \$40 / specialty care visit; <u>deductible</u> does not apply	\$15 / primary care visit; \$40 / specialty care visit; <u>deductible</u> does not apply	<u>Non-Network providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 / day up to \$1,050 / admit	Not covered	<u>Preauthorization</u> required or will not be covered.
	Physician/surgeon fees	Included in facility fee	Not covered	<u>Preauthorization</u> required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / visit Nothing for group therapy; <u>deductible</u> does not apply	Not covered	None
	Inpatient services	\$350 / day up to \$1,050 / admit	Not covered	<u>Preauthorization</u> required or will not be covered.
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply	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	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
	Childbirth/delivery facility services	\$350 / day up to \$1,050 / admit	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services <u>cost shares</u> are separate from that of the mother.
If you need help recovering or have	<u>Home health care</u>	\$15 / visit	Not covered	<u>Preauthorization</u> required or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
other special health needs	<u>Rehabilitation services</u>	Outpatient: \$15 / Primary care visit; \$40 / specialty care visit Inpatient: \$350 / day up to \$1,050 / admit	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Habilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Habilitation services</u>	Outpatient: \$15 / Primary care visit; \$40 / specialty care visit Inpatient: \$350 / day up to \$1,050 / admit	Not covered	Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year (combined with <u>Rehabilitation services</u>). Services with mental health diagnoses are covered with no limit. Inpatient: <u>Preauthorization</u> required or will not be covered.
	<u>Skilled nursing care</u>	Nothing after <u>deductible</u>	Not covered	100-day limit / year. <u>Preauthorization</u> required or will not be covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines. <u>Preauthorization</u> required or will not be covered.
	<u>Hospice services</u>	No charge	Not covered	<u>Preauthorization</u> required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 exam / 12 months
	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"> Children's glasses Cosmetic surgery Dental care (Adult and child) 	<ul style="list-style-type: none"> Hearing aids Long-term care 	<ul style="list-style-type: none"> Private duty nursing Weight loss programs
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 (8 visit limit / year) Bariatric surgery Chiropractic care (20 visit limit / year) 	<ul style="list-style-type: none"> Infertility treatment Non-emergency care when traveling outside the U.S. See FEHB Plan Brochure for information 	<ul style="list-style-type: none"> Routine eye care Routine foot care

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 (RI 73-012) 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 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: Kaiser Foundation Health Plan of Washington Member Appeal Department at 1-866-458-5479

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 1-888-901-4636.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-901-4636.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-901-4636.

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 **\$40**
- Hospital (facility) copayment **\$350**
- 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*)

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

<i>Cost Sharing</i> 500	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$770

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 **\$40**
- Hospital (facility) copayment **\$350**
- 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*)

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,650

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

- The plan's overall deductible **\$250**
- Specialist copayment **\$40**
- Hospital (facility) copayment **\$350**
- Other (x-ray) copayment **\$50**

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$950

Kaiser Permanente Nondiscrimination Notice and Language Access Services



KAISER PERMANENTE NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable federal civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

Provide free aids and services to people with disabilities to help ensure effective communication, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats)
- Assistive devices (magnifiers, Pocket Talkers, and other aids)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kaiser Permanente.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance. Please call us if you need help submitting a grievance. The Civil Rights Coordinator will be notified of all grievances related to discrimination.

Kaiser Permanente

Phone: 206-630-4636

Toll-free: 1-888-901-4636

TTY Washington Relay Service: 1-800-833-6388 or 711

TTY Idaho Relay Service: 1-800-377-3529 or 711

Electronically: kp.org/wa/feedback

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, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

For Medicare Advantage Plans Only: Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 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 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer): រយៈពេល ប្រើសិទ្ធិអភិវឌ្ឍន៍, សេចក្តីជួយជំនួយ យើងមិនគិតថ្លៃ គឺជូនសំបុត្រអាករ។ ចូរទូរស័ព្ទ 1-888-901-4636 (TTY: 1-800-833-6388 / 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。1-888-901-4636 (TTY: 1-800-833-6388 / 711) まで、お電話にてご連絡ください。

አማርኛ (Amharic): ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711)።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية: لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 رقم هاتف الصم والبكم: (711 / 1-800-833-6388).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS: 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711). **فارسی (Farsi): توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. یا 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.