

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021



KAI SER PERMANENT E® : POS Group Plan

Kaiser Permanente Insurance Company

Coverage for: Individual / Family | Plan Type: POS

Important Questions		Answers	Why this Matters:
What is the overall deductible?	KP: \$0 Non-KP: Individual \$100 / Individual + Family \$300	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.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there services covered before you meet your deductible?	Not Applicable.	You don't have to meet deductible for specific services.	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 limit until the overall family out-of-pocket limit has been met.
Are there other deductibles for specific services?	No.		Premiums, precertification penalties, balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.
What is the out-of-pocket limit for this plan?	KP: \$2,000 Individual / \$6,000 Family Non-KP: \$2,000 Individual / \$6,000 Family	Even though you pay these expenses, they don't count toward the out-of-pocket limit.	
What is not included in the out-of-pocket limit?			

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands to request a copy.**

Important Questions	Answers	Why this Matters:			
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the Kaiser Permanente network. You pay more if you use a <u>provider</u> in the <u>participating provider</u> network. 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 <u>plan</u> pays ( <u>balance billing</u> ). 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.			
<b>Do you need a referral to see a specialist?</b>	Yes (to be covered at the <u>plan provider</u> level), but you may self-refer to certain <u>specialists</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> .			
<b>⚠️ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.</b>					
Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Contracted Provider (You will pay more)	What You Will Pay Non-contracted Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	None
	<u>Specialist</u> visit	\$15/visit	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	None
	<u>Preventive care/ screening/ immunization</u>	No charge for immunizations; No Charge	No Charge	No Charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed 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)	10% <u>coinsurance</u>	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	None
	Imaging (CT/PET scans, MRI's)	10% <u>coinsurance</u>	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: Precertification required for CON and NonCON providers. Failure to precertify may result in a penalty up to \$300 per occurrence.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Contracted Provider (You will pay more)	What You Will Pay Non-contracted Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Generic drugs	\$10 retail prescription; \$20 mail order/prescription	20% <u>coinsurance</u> , but not less than \$10 retail prescription	Not Covered	KP: \$3 Maintenance Generic. Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share. Non-KP: No charge for contraceptives per PPACA up to the allowed amount. Not available through mail order.
	Preferred brand drugs	\$45 retail prescription; \$90 mail order/prescription	20% <u>coinsurance</u> , but not less than \$45 retail prescription	Not Covered	KP: \$3 Maintenance Generic. Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share. Non-KP: No charge for contraceptives per PPACA up to the allowed amount. Not available through mail order.
	Non-preferred brand drugs	\$45 retail prescription; \$90 mail order/prescription	20% <u>coinsurance</u> , but not less than \$45 retail prescription	Not Covered	KP: \$3 Maintenance Generic. Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share. Non-KP: No charge for contraceptives per PPACA up to the allowed amount. Not available through mail order.
	<u>Specialty drugs</u>	\$200 retail prescription	20% <u>coinsurance</u> , but not less than \$200 retail prescription	Not Covered	KP: Up to 30-day retail. No charge contraceptives in accordance with <u>formulary</u> guidelines. Certain drugs may be covered at a different cost share. Non-KP: No charge for contraceptives per PPACA up to the allowed amount. Not available through mail order.
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	\$15/visit Included in the facility fee	20% <u>coinsurance</u> of contracted rate 20% <u>coinsurance</u> of allowable charge	Non-KP: Precertification required for CON and NonCON. Failure to precertify may result in a penalty up to \$300 per occurrence. Non-KP: Precertification required for CON and NonCON. Failure to precertify may result in a penalty up to \$300 per occurrence.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Contracted Provider (You will pay more)	What You Will Pay Non-contracted Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$75/visit	Emergencies covered under HMO benefit.	Emergencies covered under HMO benefit.	KP: Must notify KP within 48 hours if admitted to a <u>non plan provider</u> ; Limited to initial emergency only
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Emergencies covered under HMO benefit.	Emergencies covered under HMO benefit.	Non KP: Scheduled transportation covered at 20% of allowable charges.
	<u>Urgent care</u>	\$15/visit; \$15 IN-AREA / 20% <u>coinsurance</u> (out of area)	Urgent care covered under HMO benefit.	Urgent care covered under HMO benefit.	Non KP: Covered subject to 20% <u>coinsurance</u> of allowable charge when not covered by KP as an HMO benefit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$75/day	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: Precertification required for CON and NonCON. Failure to precertify may result in a penalty up to \$300 per occurrence.
	Physician/surgeon fee	Included in the facility fee	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: Precertification required for CON and NonCON. Failure to precertify may result in a penalty up to \$300 per occurrence.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15/visit	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	None
	Inpatient services	\$75/day	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: Precertification required for CON and NonCON providers. Failure to precertify may result in a penalty up to \$300 per occurrence.
<b>If you are pregnant</b>	Office visits	No Charge/ Confirmed pregnancy	0% <u>coinsurance</u> of contracted rate	0% <u>coinsurance</u> of allowable charge	KP and Non KP: 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	Delivery: No Charge.	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	None
	Childbirth/delivery facility services	Delivery: No Charge.	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	KP: \$75/day newborn inpatient

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Contracted Provider (You will pay more)	What You Will Pay Non-contracted Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	<u>Home health care</u>	No Charge	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	KP: Physician visit covered at primary care visit copay Non-KP: Limited to 150 visits per calendar year combined for CON and NonCON providers. Private duty nursing not covered.
	<u>Rehabilitation services</u>	\$75/day (inpatient); \$15/visit (outpatient)	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: For CON and NonCON: Maximum of 60 outpatient visits per calendar year combined for Physical, Speech & Occupational Therapy. Precertification required. Failure to precertify may result in a penalty up to \$300 per occurrence.
	<u>Habilitation services</u>	Not covered	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	No Charge	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	KP: Limited to 120 days/benefit period Non-KP: CON and NonCON: Precertification required. Failure to precertify may result in a penalty up to \$300 per occurrence. Limited to 120 days per calendar year.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> diabetes equipment	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	KP: 20% for all other equipment Non-KP: CON and NonCON providers: Please see plan terms for specific limits and terms. Precertification required. Failure to precertify may result in a penalty up to \$300 per occurrence.
	<u>Hospice service</u>	No Charge	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	KP: Includes two 90-day periods, followed by unlimited number of 60-day periods Non-KP: CON and NonCON providers: Limited to a combined maximum of 210 days while insured. Precertification required. Failure to precertify may result in a penalty up to \$300 per occurrence.

If you need help recovering or have other special health needs

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Contracted Provider (You will pay more)	What You Will Pay Non-contracted Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	No Charge	20% <u>coinsurance</u> of contracted rate	20% <u>coinsurance</u> of allowable charge	Non-KP: CON and NonCON providers: Reflects copay amounts for eye exams and eyeglasses.
	Children's glasses	No Charge	100% coverage up to the allowable charge	100% coverage up to the allowable charge	KP: Only 1 annual visit for eye exam covered at no charge. Hardware limited to 1 frame and lenses (selected styles), or 1 set of contacts per contract period. Non-KP: CON and NonCON: Limited to a combined maximum of \$50 every 24 months.
	Children's dental check-up	Not Covered	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.)**

- Children's dental check-up
- Cosmetic Surgery
- Dental care (Adult)
- Habilitation services
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling
- Outside the U.S.

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (Limited to 12 combined visits/ calendar year from American Specialty Health Network)
- Bariatric Surgery
- Chiropractic Care (Limited to 12 combined visits/calendar year from American Specialty Health Network)
- Hearing Aids (Every 3 years)
- 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your plan, this notice, or assistance, contact the agencies in the chart below.

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

Kaiser Permanente Member Services	1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>
Hawaii Department of Insurance	1-808-586-2790 or <a href="http://cca.hawaii.gov/ins/">http://cca.hawaii.gov/ins/</a>

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands  
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijo holne' 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.

## 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.



<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)	<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	\$0
<u>Copayments</u>	\$10	\$900
<u>Coinsurance</u>	\$0	\$300
<i>What isn't covered</i>		
Limits or exclusions	\$0	\$0
<b>The total Peg would pay is</b>	<b>\$10</b>	<b>\$1,200</b>

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)	<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	\$0
<u>Copayments</u>	\$10	\$900
<u>Coinsurance</u>	\$0	\$300
<i>What isn't covered</i>		
Limits or exclusions	\$0	\$0
<b>The total Peg would pay is</b>	<b>\$10</b>	<b>\$1,200</b>

<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	\$0
<u>Copayments</u>	\$75	\$900
<u>Coinsurance</u>	10%	\$300
<i>What isn't covered</i>		
Limits or exclusions	\$0	\$0
<b>The total Mia would pay is</b>	<b>\$10</b>	<b>\$600</b>

<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	\$0
<u>Specialist copayment</u>	\$15	\$900
<u>Hospital (facility) copayment</u>	\$75	\$300
<u>Other (x-ray) coinsurance</u>	10%	\$0
<i>What isn't covered</i>		
Limits or exclusions	\$0	\$0
<b>The total Mia would pay is</b>	<b>\$10</b>	<b>\$600</b>

This EXAMPLE event includes services like:  
Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)  
Specialist visit (anesthesia)

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)

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

The plan would be responsible for the other costs of these EXAMPLE covered services.

## NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-966-5955 (TTY: 711)**

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: KPIC Civil Rights Coordinator, Grievance 1557, 5855 Copley Drive, Suite 250, San Diego, CA 92111, telephone number 1-888-251-7052.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call **1-800-966-5955 (TTY: 711)**.

**Cebuano (Bisaya) ATENSYON:** Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-966-5955 (TTY: 711)**.

**中文 (Chinese) 注意：**如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-966-5955 (TTY: 711)**。

**Chuuk (Chukese) MEI AUCHEA:** Ika iei foosun fonusomw. Foosun Chuuk, iwe en mei tongeni omw kopwe angel aninisin chiakkku, ese kamo. Kori **1-800-966-5955 (TTY: 711)**.

**‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI:** Ihā ho‘opuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke loa‘a i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955 (TTY: 711)**.

**Ilokano (Ilocano) PAKDAAR:** No agsasaoka iti Ilokano, dagiti awan bayadha a serbisio a para iti beddeng ti lengguahae ket sidaaan para kenka. Awagan ti **1-800-966-5955 (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。**1-800-966-5955 (TTY:711)**まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: 711)번으로 전화해 주십시오.

ລາວ (Laotian) ໃປດຊາບ: ຕ່າງວ່າ ຫາມເວົ້າພາສາ ລາວ, ການປໍລິການຂວຍເຫຼືອດານພາສາ, ໂດຍບໍ່ສູງໆ, ແມ່ນມີໜູອນໃຫຍ້ໆ, ອັນ 1-800-966-5955 (TTY: 711).

**Kajin Majōl (Marshallese) LALE:** Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ne am ejjejok wōñāñ. Kaalq 1-800-966-5955 (TTY: 711).

**Naabeehó (Navajo) Díí baa akó nínizin:** Díí saad bee yánifti'go Diné Bizaad, saad bee áká'áñída'áwo'déé', 'táá jiik'eh, éí ná hólq, koji' hódfílinih 1-800-966-5955 (TTY: 711).

**Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR:** Ma komw kin lokaiahn Pohnpei, wasahn sawas en palien lokaiak sawas ni sohite isais. Koahl nempe 1-800-966-5955 (TTY: 711).

**Faa-Samoan (Samoan) MO LOU SILAFIA:** Afai e te lautala Gagana fa'a Sāmoa, o loo lai auaunaga fesoasoani, e fai fuau e leai se tologi, mo oe, Telefoni mai: 1-800-966-5955 (TTY: 711).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (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 1-800-966-5955 (TTY: 711).

**Lea Faka-Tonga (Tongan) FAKATOKANGAI:** Kapau 'oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-800-966-5955 (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 **1-800-966-5955** (TTY: 711).