KAISER PERMANENTE®

2017 Federal Employees Rates & Benefits

Compare your plan choices

Choose the Options Federal plan that fits you and your family

Kaiser Foundation Health Plan of Washington Options, Inc.

Which choice is right for you?

There are three Kaiser Permanente Washington Options Federal choices available for 2017. You can choose the coverage that fits your needs and budget.

	HDHP WITH HSA OR HRA	STANDARD OPTION	HIGH OPTION
COMPARE DESCRIPTIONS			
Description	High Deductible Health Plan can be paired with a health savings account (HSA) or health reimbursement arrangement (HRA) through HealthEquity®. After you sign up for the HSA or HRA, you will receive a contribution to your tax-free account. For details, visit healthequity.com.	Standard Option offers a low deductible and lower premiums. Standard Option covers preventive care visits at 100 percent, and preventive dental is covered. Office visit copays are just $25 for primary and $35 for specialty care.	High Option covers preventive dental and up to $1,000 of basic and major dental procedures. High Option covers medical preventive care visits at 100 percent.
Your cost share	Lowest premium, highest deductible.[1]	Low premium, low deductible.[1]	Highest premium, lowest deductible,[1] affordable out-of-pocket costs.
May be right for you if	You and your family rarely go to the doctor and you want the lowest premium.	You want an affordable premium and predictable copays for office visits and prescriptions.	You want lower out-of-pocket costs when you see the doctor.

	HDHP WITH HSA OR HRA		STANDARD OPTION		HIGH OPTION	
COMPARE PREMIUMS: NONPOSTAL[2]						
	Biweekly / Monthly	(Code)	Biweekly / Monthly	(Code)	Biweekly / Monthly	(Code)
Self only	$59.16 / $128.18	(L14)	$73.64 / $159.56	(L11)	$203.48 / $440.87	(VT1)
Self + one	$123.41 / $267.38	(L16)	$154.65 / $335.08	(L13)	$417.01 / $903.52	(VT3)
Self + family	$138.64 / $300.38	(L15)	$201.76 / $437.15	(L12)	$515.13 / $1,116.12	(VT2)
COMPARE PREMIUMS: POSTAL[2]						
	Biweekly 1 / Biweekly 2	(Code)	Biweekly 1 / Biweekly 2	(Code)	Biweekly 1 / Biweekly 2	(Code)
Self only	$51.47 / $49.10	(L14)	$64.07 / $61.12	(L11)	$194.25 / $191.17	(VT1)
Self + one	$107.36 / $102.43	(L16)	$134.55 / $128.36	(L13)	$397.18 / $390.58	(VT3)
Self + family	$120.61 / $115.07	(L15)	$180.70 / $173.69	(L12)	$494.07 / $487.06	(VT2)

If you need help to find a plan that's right for you, call the Federal Program Sales Department at 360-478-6786.
For current members, contact Member Services toll-free at 1-888-901-4636.

See "Details and definitions" on the back for explanations of some of the terms used in this brochure.

[1]You pay the deductible amount each year before your plan starts to pay; however, preventive care is covered in full from the start.

[2]These rates do not apply to all enrollees. If you are in a special enrollment category, please refer to your special Guide to Federal Benefits or contact the agency or tribal employer which maintains your health benefits enrollment.

OPTIONS FEDERAL HIGH DEDUCTIBLE HEALTH PLAN

COVERAGE	Plan	Non-Plan
Annual deductible Self / Self Plus One / Self & Family Deductible applies to all services except as noted	$1,500 / $3,000 / $3,000	$1,500 / $3,000 / $3,000
Annual out-of-pocket limit Self / Self Plus One / Self & Family	$5,000 / $10,000 / $10,000	$5,000 / $10,000 / $10,000
Annual medical fund contribution Self / Self Plus One / Self & Family	$750 / $1,500 / $1,500	
BENEFITS (Deductible applies unless stated not subject to deductible)		
Preventive care	Covered in full, not subject to deductible	
Professional services: (Self-refer / unlimited visits) Primary & Specialty Office, Home, Naturopath & Urgent Care Visits	20% coinsurance	
Acupuncture: Self-refer 20 visits per member PCY[3] For substance abuse, unlimited visits	20% coinsurance	
Chiropractic: Self-refer 20 visits per member PCY[3]	20% coinsurance	
Massage: With a referral, 20 visits per member PCY[3]	20% coinsurance	
Mental health	20% coinsurance: Outpatient & Inpatient[4]	
Lab/X-ray	20% coinsurance	
Hospital / Facility	20% coinsurance: Outpatient & Inpatient[4]	
Emergency care	20% coinsurance	
Maternity	20% coinsurance: Prenatal care covered at 100%; not subject to deductible	
Ambulance: Ground & Air	20% coinsurance	
PRESCRIPTION DRUGS		
Tier 1: Formulary generic 1-month supply / 90-day supply	$20 copay / $40 copay	
Tier 2: Formulary brand 1-month supply / 90-day supply	$40 copay / $80 copay	
Tier 3: Non-preferred 1-month supply / 90-day supply	$60 copay / $120 copay	
Tier 4: Formulary specialty 1-month supply	25% coinsurance up to $200	
Tier 5: Non-preferred specialty 1-month supply	35% coinsurance up to $300	
DENTAL		
Preventive Dental	All charges in excess of scheduled allowance	
Basic & Major Dental Services Deductible: Self / Self Plus One / Self & Family No annual maximum for children through age 17	N/A	
VISION		
Annual routine eye exam	Covered in full; not subject to deductible	
Diagnostic eye exams	Deductible and 20% coinsurance	
Eyeglasses or contact lenses Accident or surgery related	Deductible and 20% coinsurance	
Hardware[5]	20% discount	
WORLDWIDE TRAVEL BENEFIT (OUTSIDE WA STATE)	**You pay applicable benefit cost shares**	

[3]PCY = Per calendar year [4]Inpatient requires preauthorization

[5]These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and eligible family members who become members of Kaiser Permanente Washington Options Federal.

Please note that the above information is a summary of the Kaiser Permanente Washington Options Federal benefits. Before making a final decision, please read the Plan's Federal brochure (RI 73-051). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure. Please refer to the 2017 Kaiser Permanente Washington Options Federal (formerly Group Health Options, Inc.) brochure posted at kp.org/wa/fehb-options

OPTIONS FEDERAL STANDARD OPTION

COVERAGE	Plan	Non-Plan
Annual deductible Self / Self Plus One / Self & Family Deductible applies to all services except as noted	$350 / $700 / $700	Shared with Plan
Annual out-of-pocket limit Self / Self Plus One / Self & Family	$5,000 / $10,000 / $10,000	Unlimited
Annual medical fund contribution Self / Self Plus One / Self & Family	N/A	N/A
BENEFITS (Deductible applies unless stated not subject to deductible)		
Preventive care	Covered in full, not subject to deductible	
Professional services: (Self-refer / unlimited visits) Primary & Specialty Office, Home, Naturopath & Urgent Care Visits	$25 copay primary / $35 copay specialty; not subject to deductible	
Acupuncture: Self-refer 20 visits per member PCY[3] For substance abuse, unlimited visits	$25 copay primary / $35 copay specialty; not subject to deductible	
Chiropractic: Self-refer 20 visits per member PCY[3]	$25 copay primary / $35 copay specialty; not subject to deductible	
Massage: With a referral, 20 visits per member PCY[3]	$25 copay primary / $35 copay specialty; not subject to deductible	
Mental health	Inpatient[4]: 20% coinsurance Outpatient: $25 copay primary / $35 copay specialty; not subject to deductible	
Lab/X-ray	20% coinsurance	
Hospital / Facility	20% coinsurance: Outpatient & Inpatient[4]	
Emergency care	20% coinsurance	
Maternity	Covered in full; not subject to deductible	
Ambulance: Ground & Air	20% coinsurance	
PRESCRIPTION DRUGS		
Tier 1: Formulary generic 1-month supply / 90-day supply	$20 copay / $40 copay	
Tier 2: Formulary brand 1-month supply / 90-day supply	$40 copay / $80 copay	
Tier 3: Non-preferred 1-month supply / 90-day supply	$60 copay / $120 copay	
Tier 4: Formulary specialty 1-month supply	25% coinsurance up to $200	
Tier 5: Non-preferred specialty 1-month supply	35% coinsurance up to $300	
DENTAL		
Preventive Dental	All charges in excess of scheduled allowance	
Basic & Major Dental Services Deductible: Self / Self Plus One / Self & Family No annual maximum for children through age 17	N/A	
VISION		
Annual routine eye exam	Covered in full; not subject to deductible	
Diagnostic eye exams	$25 copay primary / $35 copay specialty; not subject to deductible	
Eyeglasses or contact lenses Accident or surgery related	Deductible and 20% coinsurance	
Hardware[5]	20% discount	
WORLDWIDE TRAVEL BENEFIT (OUTSIDE WA STATE)	**You pay applicable benefit cost shares**	

[3]PCY = Per calendar year [4]Inpatient requires preauthorization

[5]These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and eligible family members who become members of Kaiser Permanente Washington Options Federal.

Please note that the above information is a summary of the Kaiser Permanente Washington Options Federal benefits. Before making a final decision, please read the Plan's Federal brochure (RI 73-051). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure. Please refer to the 2017 Kaiser Permanente Washington Options Federal (formerly Group Health Options, Inc.) brochure posted at kp.org/wa/fehb-options

OPTIONS FEDERAL HIGH OPTION

COVERAGE	Plan	Non-Plan
Annual deductible Self / Self Plus One / Self & Family Deductible applies to all services except as noted	$100 / $200 / $200	Shared with Plan
Annual out-of-pocket limit Self / Self Plus One / Self & Family	$5,000 / $10,000 / $10,000	Unlimited
Annual medical fund contribution Self / Self Plus One / Self & Family	N/A	N/A
BENEFITS (Deductible applies unless stated not subject to deductible)		
Preventive care	Covered in full	
Professional services: (Self-refer / unlimited visits) Primary & Specialty Office, Home, Naturopath & Urgent Care Visits	$30 copay per office visit; not subject to deductible	
Acupuncture: Self-refer 20 visits per member PCY[3] For substance abuse, unlimited visits	$30 copay per visit; not subject to deductible	
Chiropractic: Self-refer 20 visits per member PCY[3]	$30 copay per visit; not subject to deductible	
Massage: With a referral, 20 visits per member PCY[3]	$30 copay per visit; not subject to deductible	
Mental health	Inpatient[4]: 20% coinsurance Outpatient: $30 copay per visit; not subject to deductible	
Lab/X-ray	20% coinsurance	
Hospital / Facility	20% coinsurance: Outpatient & Inpatient[4]	
Emergency care	$150 copay per visit; copay waived if admitted	
Maternity	Covered in full	
Ambulance: Ground & Air	20% coinsurance	
PRESCRIPTION DRUGS		
Tier 1: Formulary generic 1-month supply / 90-day supply	$10 copay / $20 copay	
Tier 2: Formulary brand 1-month supply / 90-day supply	$35 copay / $70 copay	
Tier 3: Non-preferred 1-month supply / 90-day supply	$60 copay / $120 copay	
Tier 4: Formulary specialty 1-month supply	25% coinsurance up to $200	
Tier 5: Non-preferred specialty 1-month supply	35% coinsurance up to $300	
DENTAL		
Preventive Dental	All charges in excess of scheduled allowance	
Basic & Major Dental Services Deductible: Self / Self Plus One / Self & Family No annual maximum for children through age 17	$25 / $50 / $50 All charges in excess of scheduled allowance $1,000 annual maximum for adults 18 and older	
VISION		
Annual routine eye exam	Covered in full	
Diagnostic eye exams	$30 copay per visit; not subject to deductible	
Eyeglasses or contact lenses Accident or surgery related	20% coinsurance	
Hardware[5]	20% discount	
WORLDWIDE TRAVEL BENEFIT (OUTSIDE WA STATE)	**You pay applicable benefit cost shares**	

[3]PCY = Per calendar year [4]Inpatient requires preauthorization

[5]These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and eligible family members who become members of Kaiser Permanente Washington Options Federal.

Please note that the above information is a summary of the Kaiser Permanente Washington Options Federal benefits. Before making a final decision, please read the Plan's Federal brochure (RI 73-051). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure. Please refer to the 2017 Kaiser Permanente Washington Options Federal (formerly Group Health Options, Inc.) brochure posted at kp.org/wa/fehb-options

How to get care when you're not near an in-network clinic

How will I get care anywhere with a Kaiser Permanente plan?

Kaiser Foundation Health Plan of Washington Options, Inc. federal plans use the Options Federal network, which includes First Choice Health network and First Health Network, so you can be assured that you're covered:

- You may self-refer to health care providers—with just a few exceptions. Referrals are required for speech, occupational, physical, and massage therapy providers.
- Outside the state of Washington, find a First Choice Health network or First Health Network provider.

If you receive care from non-plan providers and facilities, such as non-affiliated hospitals or medical centers, you may need to pay in full at the time of service. But don't worry, just mail us your completed claims form and medical receipts so we can reimburse you for any covered charges.

To get a claims form, visit kp.org/wa, and click "Request reimbursement" on the right. Or you can request a form by calling Member Services toll-free at 1-888-901-4636.

How do I find a provider when I'm traveling?

You can always call Member Services toll-free at 1-888-901-4636 for assistance. Your health care dollars will go further when you use our preferred regional and national networks, the First Choice Health network and the First Health Network. Find out more about these networks in our online Provider and Facility Directory; you'll find the link at kp.org/wa/fehb-options.

How do I get a prescription?

No matter where you get care, you can use thousands of convenient pharmacy locations for your prescription needs. We also offer an extensive nationwide pharmacy network—OptumRx.

To find an in-network pharmacy near you, check out our Provider and Facility Directory; the link is at kp.org/wa/fehb-options.

For most refills that have been filled at least once at a Kaiser Permanente pharmacy or that have been transferred into our pharmacy system, you can phone in your prescription, use the Kaiser Permanente mobile app (kp.org/wa/mobile), or make a request online (kp.org/wa/pharmacy) for pick-up at a Kaiser Permanente pharmacy or for home delivery by mail.

For more information, visit kp.org/wa/fehb-options and click on for "Pharmacy Services."

How do I get a prescription in an emergency when I'm traveling?

Outpatient medications prescribed or dispensed as a part of an emergency or urgent situation will be covered. You may be required to pay for the total cost of the prescription up front, but you can submit a request form for reimbursement upon your return home.

To get a claims form, visit kp.org/wa, and click "Request reimbursement" on the right. Or you can request a form by calling Member Services toll-free at 1-888-901-4636.

Why choose Kaiser Permanente Washington Options Federal

The network: Access almost everywhere

The Options Federal network offers you a broad choice of in-network professionals and facilities, so you can find the doctor who's right for you wherever you are. It's also the only network that gives you access to the highest rated doctors[6] in the state at Kaiser Permanente medical offices, and lets you choose from any licensed provider throughout the state. Plus, you get access to more than 600,000 in-network providers with the regional First Choice Health network and national First Health Network.

In-network providers. Access to:

- An extensive network of physicians and other providers who contract directly with Kaiser Permanente
- In-network care from First Choice Health providers located in Washington, Oregon, Idaho, Alaska, and Montana
- In-network care outside Washington, Oregon, Idaho, Alaska, and Montana from First Health Network's providers in all states nationwide

Out-of-network providers. Access to:

Out-of-network care from any licensed provider, medical facility, and hospital in the country

Out-of-area coverage. Access to:

Routine, urgent, and emergency care anywhere in the world

The benefits: Get the care you need

Alternative care

All plans include naturopathy, acupuncture, chiropractic, and massage therapy benefits.

Dental care

All plans include preventive dental care benefits. The High Option plan also covers basic and major dental services. You can see any licensed dentist.

Health and wellness programs

Included in your plan at no extra charge are preventive care reminders, GlobalFit® fitness club discounts, nutrition program discounts, and a smoking cessation program.

Vision hardware

Annual routine eye exams are covered at 100 percent. Also, obtain discounts on frames, lenses, contacts, and OSHA-approved safety goggles at Kaiser Permanente Eye Care optical centers.[7]

[6]Formerly Group Health Cooperative, highest-ranked medical group in Washington state, Washington Health Alliance, 2016 Community Checkup

[7]These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and eligible family members who become members of Kaiser Permanente Washington Options Federal.

Details and definitions

Coinsurance

The percentage amount you pay for the cost of your covered care or prescriptions. For example, you might pay 20 percent of the cost of your office visit each time you see your doctor.

Copayment, copay

The set dollar amount you pay for certain covered services. For example, you might pay a $25 copay each time you see your doctor.

Deductible

What you'll pay each year before your plan starts to pay its share. For certain services, such as preventive care, the deductible does not apply.

Formulary

The list of generic and brand-name prescription drugs that are usually covered by our health plans. The drugs are selected by a committee of Kaiser Permanente physicians and pharmacists based on safety, effectiveness, and cost.

Health savings account (HSA)

An HSA is a personal savings account you use to pay for eligible medical expenses. The money you deposit into your account is not taxed, and you own and control that money, even if you change employers.

Health reimbursement arrangement (HRA)

If you aren't eligible for an HSA, an HRA is an account set up for you by your employer and is used to pay for eligible medical expenses. The money deposited into the account is not taxed. Only the employer can contribute to an HRA and the employer controls the account.

Hospital stays—inpatient

Hospital room and board; inpatient surgery; anesthesia; intensive and coronary care; laboratory tests; radiology services; and drugs while in the hospital. Includes mental health inpatient treatment.

Out-of-pocket maximum

The most you'll be required to pay for covered services in a calendar year. After you've paid this amount, the health plan pays for all covered services for the remainder of the year. Deductible, coinsurance, and copays count toward this maximum, but plan premiums do not.

Outpatient surgery

Surgery in an office, outpatient surgery center, or hospital setting that does not require an overnight stay.

Prescription drugs

Outpatient: Formulary drugs and medicines that require prescriptions, including self-administered injectables, mental health drugs, and diabetic supplies.

Preventive care services

For children and adults. Includes wellness visits and immunizations, as established in Kaiser Permanente's well-care schedule, formulary contraceptive drugs including counseling, contraceptive devices, and female sterilization and counseling. Devices and supplies related to contraception are covered as preventive as required by federal law and covered in full. Also includes drugs and medicines such as aspirin, fluoride, and folic acid.

Kaiser Permanente Nondiscrimination Notice and Language Access Services

KAISER PERMANENTE®

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 on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Kaiser Permanente:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides 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 Member Services.

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 by phone, mail, fax, or email. If you need help filing a grievance, a Kaiser Permanente Member Services Representative is available to help you. Language assistance is provided free of charge.

Kaiser Permanente Member Services

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
Fax: 206-901-6205 or toll-free 1-888-874-1765
Address: PO Box 34593, Seattle, WA 98124-1593
Email: csforms@ghc.org

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.

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak 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)**៖ បរយ័ត៖** បើសិនអកនិយាខែរ, សេជំនួយែជក យេមិនគិតល គឺចនសំប់បំរេអក។ ចូរទូរស័ព 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)፥ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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).

العربية (Arabic): 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: 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।

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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.