

Questions and answers

Set up a health savings account (HSA) to help pay for care.¹



Understanding your Plan

What is the HSA-Qualified Deductible EPO Plan?

This plan gives you access to high-quality care and resources to help you feel your best. Plus, it offers flexibility in how you can pay for care.

With your Plan, you'll need to pay the full cost for most covered services until you reach a set amount known as your deductible. After you reach your deductible, you'll start paying less for the rest of the year – just a copay or a coinsurance (which is a percentage of the total cost). And most preventive care services (like routine physical exams, mammograms, and cholesterol screenings) are covered at no cost or at a copay – even before you reach your deductible.²

Also, with your Plan, if eligible, you can set up a health savings account (HSA) that you can access anytime to pay for care – including copays, coinsurance, and deductible payments.¹ And you won't pay federal taxes on the money in this account.³

What is a health savings account (HSA)?

An HSA is a financial account that you can put money into in order to pay for health care services that are defined as qualified medical expenses. You won't pay federal taxes on this money, and you can use it anytime to pay for care. Your account may earn interest, and you can take your money with you if you change jobs or retire.

What are qualified medical expenses?

Qualified medical expenses are defined by the Internal Revenue Service (IRS) for tax purposes. They include many health care services and related costs, such as:

- Primary and specialty care visits
- Non-cosmetic dental care
- X-rays and lab tests
- Eyeglasses and LASIK vision correction
- Hospital visits
- Prescription drugs

For a detailed list, see IRS Publication 502, *Medical and Dental Expenses*, available at [irs.gov/publications](https://www.irs.gov/publications).

How do deductible plans work?

With a deductible plan, you get all the quality care and resources people expect from Kaiser Permanente. The main difference is how you pay for care.

- You'll need to pay the full cost for covered services until you reach a set amount known as your deductible. For example, a \$1,500 deductible means you'll pay the full cost of your care and services up to \$1,500.
- After you reach your deductible, you'll start paying less for the rest of the year – just a copay or a coinsurance.
- Most preventive care services are covered at no cost or at a copay, even before you reach your deductible.²
- See your *Summary Plan Description* for your Plan details, including the date your deductible will reset.

Your Plan also has an out-of-pocket maximum that helps limit how much you'll pay for care. If you reach it, you won't have to pay for covered services for the rest of the year. This can help protect you financially if you ever have a serious illness or injury.

- Payments for most covered services count toward your out-of-pocket maximum.⁴
- Copays and coinsurance don't count toward your deductible, but they do help you reach your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, your Plan will pay for all covered services for the rest of the year.
- See your *Summary Plan Description* and other Plan documents for further details, including the date your out-of-pocket maximum will start over.

Do I need to reach my deductible before I can pay a copay or coinsurance for preventive care?

No. Most preventive care is covered at no cost or at a copay,² even before you reach your deductible.

What is preventive care?

Preventive care can help you avoid illness and protect your health. Your Plan offers many preventive care services at no cost or at a copay,² including:

- Routine physical exams
- Well-child visits
- Scheduled prenatal care
- Hearing tests
- Immunizations
- Routine well-woman visits, including mammograms, pelvic exams, clinical breast exams, and Pap tests
- Diabetes screenings
- Prostate cancer screenings, including prostate-specific antigen (PSA) tests
- Cholesterol screenings
- Colonoscopy screenings

For more information, see your *Summary Plan Description* and other Plan documents.

I got preventive care and was billed for more than I expected. Why?

There may be times when you come in for preventive care and need non-preventive care services, too. For example, during a routine physical exam your doctor might find a mole that needs to be removed for testing. Because the removal and testing of the mole are non-preventive care services, you'll get a bill for them.

How do my deductible and out-of-pocket maximum work?

All HSA-qualified deductible EPO plans have a deductible and an out-of-pocket maximum.

- For an individual plan, the individual deductible must be met first. This means that you need to reach your deductible before you can pay copays or coinsurance for covered services. There's an exception for most preventive care services, which are covered at no cost or at a copay.²
- All copays, coinsurance, and deductible payments count toward your out-of-pocket maximum. For an individual plan, once you reach the individual out-of-pocket maximum, your Plan will pay for all of your covered services for the rest of the year.
- For family coverage (2 or more members), there is one deductible for the whole family. This is reached once the payments for covered services add up to this amount – whether the payments are for an individual family member or for various family members combined.
- Once the family deductible is met, then all covered family members will start paying copays or coinsurance for covered services.
- In addition to the family deductible, there is an individual out-of-pocket maximum and a family out-of-pocket maximum. Once the individual or family out-of-pocket maximum is met, Kaiser Permanente will pay for all covered services for the individual or the entire family for the rest of the year.
- See your *Summary Plan Description* for your Plan details, including the date your deductible and out-of-pocket maximum will start over.

Do copays, coinsurance, and deductible payments count toward my out-of-pocket maximum?

Yes. Payments for all covered services count toward your out-of-pocket maximum.

For example, let's say you had a deductible of \$1,500 and an out-of-pocket maximum of \$3,000. After reaching your \$1,500 deductible, all of your copays and coinsurance would count toward your out-of-pocket maximum.

Deductible: \$1,500

Out-of-pocket maximum: \$3,000

Difference: \$1,500. In other words, after reaching your deductible, you'd need to pay \$1,500 worth of copays or coinsurance to reach your out-of-pocket maximum.

With HSA-qualified plans, medical and pharmacy services have one combined deductible.

Will what I pay for count towards my:

	Deductible	Out-of-pocket maximum
Most preventive services	No	Yes
All other covered services	Yes	Yes
Prescription drugs	Yes	Yes

What medical services count toward my deductible and out-of-pocket maximum?

Preventive services will count toward your out-of-pocket maximum, but not your deductible. Payments for all other covered services will be applied toward both. Covered services can include:

- Doctor's office visits (for both primary and specialty care)
- Hospitalization
- Inpatient/outpatient surgery
- Emergency services
- Ambulance services
- Urgent care
- X-ray, MRI, CT scan, lab tests
- Prescription drugs

For more information about your benefits, please refer to your *Summary Plan Description*.

Can I see a Kaiser Permanente doctor with this Plan?

Yes. Kaiser Permanente doctors are included in your Plan's physician network.



More about HSAs

What can I pay for with my HSA?

You can use the money in your HSA to pay for copays, coinsurance, and deductible payments for you and your dependents.¹ Examples include:

- Emergency services
- Hospital visits
- Prescription drugs
- Primary and specialty care visits
- X-rays and lab tests

For a detailed list of HSA-covered services, see Publication 502 on the IRS website.

For more information about your benefits, refer to your *Summary Plan Description*.

How do I use my HSA to pay for care?

You can use your HSA to pay for care 3 ways:

Debit card

If you have an HSA debit card, use it either:

- When you get care, or
- By writing your card number on your bill and sending it in.

Reimbursement

Pay out of pocket using your own money, then get reimbursed by submitting a distribution request to your HSA administrator.

Combination

If you don't have enough money in your HSA to cover the full cost of your care, you can use the remaining money available in your HSA and then pay the difference with another form of payment.

Who is eligible for an HSA?

To be eligible for an HSA, you need to meet the following requirements:

- You must be enrolled in an HSA-qualified deductible health plan.
- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not an HSA-qualified deductible plan. (There are certain exceptions, including specific injury insurance or coverage for accidents, disability, dental care, vision care, or long-term care.)

You may want to consult with a financial advisor for more information about HSA eligibility.

Who can contribute to an HSA?

You, your family members, your employer, and anyone else can put money in your HSA. The annual limit on the amount of money you can add to your account applies no matter who makes contributions.

How much can I contribute per year?

For 2020, annual contributions to an HSA are capped at \$3,550 for individuals and \$7,100 for families. These maximums may be changed for inflation each year. You may contribute to your account for the current year until your tax filing due date (for most people, this is April 15 of the following year).

When can I start using my HSA?

You can use your HSA once you've opened the account and put money in it.

When should I submit requests for reimbursement for care I paid for out of pocket?

You can submit a request for reimbursement anytime, as long as you got the care on or after the date you opened the HSA.

If you have more questions, please contact your HSA administrator.

What if I leave my current employer or retire with money still in my HSA?

The money in your HSA belongs to you. If you leave your company, you can take your HSA with you.

What if there's money left in my account at the end of the year?

Any money left in your HSA at the end of the year will be available for you to use in the future.

What if I use all the money in my HSA before the end of the year?

If you use all of the money in your HSA, and have already contributed the maximum amount allowed for the year, you'll have to pay out of pocket for any other health care expenses until the end of the year.

Can I put more money in my HSA than the amount of my health plan deductible?

The maximum amount you can contribute to your HSA is set by the federal government on a yearly basis. The decided amount is unrelated to your deductible.

If my coverage starts in the middle of the year, how much can I contribute to my HSA?

If you start your health plan in the middle of the year, you can still contribute up to the maximum dollar amount set by the federal government for that year.

Here are important timeframes to remember when contributing to your HSA:

- You must be enrolled in an HSA-qualified deductible plan for at least the full month of December to contribute to your HSA for that year.
- You need to stay enrolled for the full calendar year following your midyear enrollment. If you don't stay enrolled for the full period, a portion of the maximum contribution you made will be included in your taxable income for the year. This means you would have to pay taxes and penalties on a portion of your contribution.

Can I make my entire HSA contribution at the beginning of the year?

Yes. As long as you don't go over your annual limit, you can contribute as much as you'd like at the beginning of the year. If your eligibility status changes during the year, you may have to correct the amount you already contributed. For example, if you change from family to individual coverage during the year, you might have contributed too much.

Can I make extra contributions if I'm 55 or older?

Yes. If you're 55 or older, you can make an additional contribution of up to \$1,000.

For more information about HSAs, visit the **U.S. Treasury Department's information webpage**.

What are the advantages of an HSA?

- You don't pay taxes on the money that you put into your HSA.³
- You can continue to save and grow the account for care later in life, such as after you retire.

How do I get started?

There are 2 ways to set up an HSA:

1. If your employer offers you an HSA, follow the instructions that your employer provides.
2. If you choose your own financial institution for your HSA, follow the instructions that your financial institution provides.

Paying for care

What can I expect to pay for a visit?

To find out how much you can expect to pay when you check in, you can:

- Use our Estimates tool at kp.org/costestimates.
- Once your plan is effective, you can call the Customer Service number on your ID card for assistance.

When you come in for care, you'll make a payment for your scheduled services. Note that this may be only a deposit toward the total cost of scheduled services as indicated on our Estimates tool. If that is the case, or if you get any unscheduled services during your visit, you'll get a bill for the difference later. See your *Summary Plan Description* or call the number on your Kaiser Permanente ID card for more information.

Accessing care

Where can I get care?

Kaiser Permanente has more than 15,000 physicians in California. And you'll find about 500 medical facilities in Northern and Southern California. To make your care experience as easy and convenient as possible, most facilities offer many services in one location. You can also get many services during evenings and weekends.

If I have a medical emergency⁵ while away from home, will my care be covered?

Yes. Your Plan covers emergency care from providers anywhere in the world. Please see your *Summary Plan Description* or visit kp.org/travel for more information.

If I have questions about getting care, who can I talk to?

Please refer to your *Summary Plan Description* or your employer's Plan documents.

Once your plan is effective, you can call the Customer Service number on your ID card for assistance.

Common terms

Coinsurance	From the total cost of a covered service, the percentage you pay is the coinsurance. For example, a 20% coinsurance for a \$200 medical procedure means you pay \$40.
Copayment (copay)	The set amount you pay for covered services (for example, a \$10 copay for an office visit).
Deductible	The amount you pay each year for covered services before your Plan starts paying. For example, a \$1,500 deductible means you'll pay the full amount for health care services up to \$1,500 before you start paying copays or coinsurance.
Out-of-pocket maximum	The most you'll pay for covered services each year.
Preventive care services	Preventive care services are types of routine care that can help keep you healthy. These services can help you find and address potential health problems before they become serious.

¹You can use your HSA to pay for types of care that are defined as qualified medical expenses by the IRS. These are described in IRS Publication 502, *Medical and Dental Expenses*, available at [irs.gov/publications](https://www.irs.gov/publications). As an HSA holder, you'll ultimately be responsible for determining whether an expense is a qualified medical expense under the tax laws.

²Depending on your plan, preventive care services are covered at no cost or at a copay. For more information, please refer to your *Summary Plan Description* and other Plan documents.

³The tax references in this document relate to federal income tax only. Consult with your financial or tax advisor for information about state income tax laws. Federal and state tax laws and regulations are subject to change. If tax, investment, or legal advice is required, seek the services of a qualified professional.

⁴If your Plan includes an Allowance for specific Services (such as eyeglasses or contact lenses), any amounts you pay that exceed the Allowance do not count toward your out-of-pocket maximum.

⁵If you reasonably believe you have an emergency medical condition, call **911** or go to the nearest Emergency Department. An emergency medical condition is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health. For the complete definition of an emergency medical condition, please refer to your *Summary Plan Description* and other Plan documents.

Your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company (One Kaiser Plaza, Oakland, CA 94612) provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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 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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, MediCal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), MediCal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles (Office for Civil Rights), en ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697(línea TDD). Los formularios de queja formal están disponibles en www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計劃成員服務聯絡中心提供語言協助服務；每週七天**24**小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以方便您使用本機構的設施與服務。此外，您還可請求以您的語言提供健康保險計劃資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電**1-800-757-7585**（TTY專線使用者請撥**711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用爭議解決方案，請參閱您的《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或者與計劃成員服務代表交談。對於Medicare、MediCal、MRMIP、MediCal Access、FEHBP或CalPERS計劃成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：

- 於設在本計劃服務設施的某個計劃成員服務處填妥一份《投訴或保險福利索償/請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 將您的冤情申訴書郵寄至設在本計劃服務設施的某個計劃成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 免費致電本機構的計劃成員服務聯絡中心，電話號碼是**1-800-757-7585**（TTY專線使用者請撥**711**）
- 在本機構的網站上填妥一份冤情申訴書，網址是**kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計劃成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給**Kaiser Permanente**的民權事務協調員（Civil Rights Coordinator）。您也可與**Kaiser Permanente**的民權事務協調員直接聯絡；聯絡地址是 One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以採用電子方式透過民權辦公處（Office for Civil Rights）的投訴入口網站（Civil Rights Complaint Portal）向美國衛生與公共服務部民權辦公處（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是ocrportal.hhs.gov/ocr/portal/lobby.jsf；或者按照如下聯絡資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD專線）。可從網站上下載投訴書，網址是 www.hhs.gov/ocr/office/file/index.html。

Language Assistance Services

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

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

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

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

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

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

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

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

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោង មួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈ ដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែ ទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយ ថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

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

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibaa' dǫ́í' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejǫ́. Atah halne'é áká'adoolwołogíí jókí, t'áadoo le'é t'áá hóhazaadjí hadilyaa'go, éí doodaii' nááná lá al'aa'adaat'ehígíí bee hádadilyaa'go. Kojí hodiilnih **1-800-464-4000**, naadiin doo bibaa' dǫ́í' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejǫ́ [Dahodiyin biniiyé e'e'aahgo éí da'deelkaaló. TTY chodeeyoolínigíí kojí hodiilnih **711**

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

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

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

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

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

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