PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Kodiak Island Borough School District
Group Number: 4020427

Effective Date: 07/01/2023

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**2023 AK HS HDHP $3,500/0%/$3,500 NGF, a Kodiak Island Borough School District plan administered by Premera Blue Cross Blue Shield of Alaska***	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$3,500 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$3,500 PCY	Unlimited
Office Visit Cost Share	In Network Deductible, then 0%	In Network Deductible, then 0%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Covered In Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 0%	In Network Deductible, then 0%
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 0%	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Chronic Condition Management (Full Program (Diabetes prevention, diabetes management, and hypertension))	Covered in Full	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Other Professional Diagnostic Imaging	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Diagnostic Mammography	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Inpatient Professional Services	In Network Deductible, then 0%	In Network Deductible, then 0%
Outpatient Surgery Facility	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Ded; then Hospital /Based CD 40% Other Facilities: Same as In network
Outpatient Facility	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Ded; then Hospital /Based CD 40% Other Facilities: Same as In network
Skilled Nursing Facility (90 days PCY)	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Inpatient: Unlimited; Respite: 240 hours; 6 month limit)	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Home Health Visits (130 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
MATERNITY & REPRODUCTIVE CARE		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Contraceptive Management Services (Unlimited)	Covered in Full	Covered In Full
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Sterilization - Male (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 0%	In Network Deductible, then 0%
Transplants (Unlimited; $75,000 Donor and $5,000 Travel and lodging)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	$3,500 PCY Deductible, then 0%	$3,500 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 0%	In Network Deductible, then 0%
Emergency Room Physician	In Network Deductible, then 0%	In Network Deductible, then 0%
Urgent Care Center	In Network Deductible, then 0%	Same as in-network cost share, (highest benefit level)
Ambulance Transportation (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Air Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then 60%
ALTERNATIVE CARE		
Acupuncture (Not Covered)	Not Covered	Not Covered
Manipulations (Spinal and other) (20 Visits PCY)	Deductible then 0% Coinsurance	Deductible then 0% Coinsurance
CHEMICAL DEPENDENCY & MENTAL HEALTH		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 0% Preferred	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 0% Preferred	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
PHARMACY		
Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core Plus (Buy-Up))	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Retail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 0%	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 0%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (Unlimited)	In Network Deductible, then 0% Preferred/0% Participating	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 0%	In Network Deductible, then 0%
TMJ (Temporomandibular Joint Disorders) (Unlimited)	Covered as any other service	Covered as any other service
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD Facility: 40%; Other Facilities and Professionals: Same as In-Network
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hearing Hardware ($400 per 36 months)	Deductible, then covered in full up to $400 per 36 months	Deductible, then covered in full up to $400 per 36 months
ANNUAL PLAN MAXIMUM		

MEDICAL PLAN	2023 AK HS HDHP $3,500/0%/$3,500 NGF, a Kodiak Island Borough School District plan administered by Premera Blue Cross Blue Shield of Alaska*	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Annual Plan Maximum	Unlimited	Unlimited

This plan is self-funded by Kodiak Island Borough School District, which means that Kodiak Island Borough School District is financially responsible for the payment of plan benefits. Kodiak Island Borough School District has the final discretionary authority to determine eligibility for benefits and construe the terms used in this plan.

Kodiak Island Borough School District has contracted with Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan.

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Vision Care Coverage

Kodiak Island Borough School District

Group Number: 4020427

Effective Date: 07/01/2023

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Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

VISION PLAN	**2023 VISION, a Kodiak Island Borough School District plan administered by Premera Blue Cross Blue Shield of Alaska***	
	IN-NETWORK	**OUT-OF-NETWORK**
VISION SERVICES		
Routine Vision Exam (1 PCY)	$20 PCY	$20 PCY
Vision Hardware (Lenses 1 PCY; Frame 1 per 2CY up to $165)	$20 PCY	$20 PCY

Funding Account Setup – For Groups

Employer Information

♦♦♦
♦

Check One:

☐ We are setting up new funding account(s).

☐ We are renewing. →
- ☐ and we have **no** account changes. *If you offer an FSA or HSA, please complete Section 5.*
- ☐ and we need to make changes.

If you are a renewing employer, please contact your sales representative for a summary document and pre-populated form from the previous year.

☐

Our employer group number is: **4020427**

Employer's legal name (same name that is used on the health plan): Kodiak Island Borough School District		Tax ID number: 926000106
Street address: 722 MILL BAY RD		
City: AKHIOK	State: AK	ZIP: 99615
Mailing address (if different than street address):		
Employer type: ☐ Sole Proprietor ☐ LLC ☐ S-Corporation ☐ Other		
Number of eligible employees: 230	Plan effective date: 07/01/2023	Plan end date: 06/30/2024

You–the employer contact or representative: SANDY DAWS		Title:
Phone number: 9074867557	Fax number:	Email address: sdaws01@kibsd.org

Highlights of your Personal Funding Accounts

Kodiak Island Borough School District

Group Number: 4020427

Effective Date: 07/01/2023

Below is a brief description of the key features of the funding account(s) your employer has chosen to offer.

FUNDING - CDH PLAN	**2023 HSA, a Kodiak Island Borough School District plan administered by Premera Blue Cross Blue Shield of Alaska***
FUNDING ACCOUNT SETUP	
Setup/Renewal	Initial Account Setup (New to vendor)
PACKAGED FUNDING OPTIONS	
Funding Options	A La Carte
HEALTH SAVINGS ACCOUNTS (HSA)	
HSA Option	NBT
CONTRIBUTION	
Contribution File Format	Online Employer Dashboard
HEALTHCARE CLAIMS SUBMISSION	
Debit Card or Streamlined Claims	HSA Payment Card with Streamlined claims (Recommended)
Streamlined Claims: Payment Method	Click-to-Pay Only
Streamlined Claims: Payee	Payment made to the Employee or Provider

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Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
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Highlights of your Dental Coverage

Kodiak Island Borough School District

Group Number: 4020427

Effective Date: 07/01/2023

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DENTAL PLAN	**2023 DENTAL $50/0%/20%/50%/$2,000, a Kodiak Island Borough School District**	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$2,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

Kodiak Island Borough School District

Group Number: 4020427

Effective Date: 07/01/2023

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DENTAL PLAN	2023 DENTAL $50/0%/20%/50%/$2,000, a Kodiak Island Borough School District	
	IN-NETWORK	OUT-OF-NETWORK
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

Kodiak Island Borough School District

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DENTAL PLAN	**2023 DENTAL $50/0%/20%/50%/$2,000, a Kodiak Island Borough School District**	
	IN-NETWORK	**OUT-OF-NETWORK**
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. 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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

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 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

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。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.

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