**Kaiser Permanente: KP MD Bronze 5000/50/Dental/PedDental**  
**Coverage Period:** Beginning on or after 01/01/2017  
**Coverage for:** Individual/Family | **Plan Type:** HMO

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### Important Questions

| **What is the overall deductible?** | **$5,000 person/$10,000 family** | **Why this Matters:** You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. Rx Deductible (Doesn't apply to Generic): **$750** person in network. There are no other specific **deductibles**. | **Why this Matters:** You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For **Plan Provider $7,150** person / **$14,300** family | **Why this Matters:** The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges (unless balance-billing is prohibited), and health care this plan does not cover. | **Why this Matters:** Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | **Why this Matters:** The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of preferred providers, see www.kp.org or call **800-777-7902**. | **Why this Matters:** If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | Yes. A written referral is required to see a Plan specialist. You may self refer to certain specialists. | **Why this Matters:** This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist. |
| **Are there services this plan doesn’t cover?** | Yes. | **Why this Matters:** Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

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Questions: Call **800-777-7902** or **1-301-879-6380 or 711** (TTY) or visit us at www.kp.org. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **800-777-7902** or **1-301-879-6380 or 711** (TTY) to request a copy.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a Plan Provider</th>
<th>Your cost if you use a Non-Plan Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$50/visit</td>
<td>Not Covered</td>
<td>Copayment waived for children under age 5. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$70/visit after deductible</td>
<td>Not Covered</td>
<td>——————————none——————————</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$50/visit after deductible</td>
<td>Not Covered</td>
<td>Acupuncture covered when medically necessary. Chiro limited to 20 visits per condition per year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Cost-sharing will apply if non-preventive services are provided during a scheduled preventive visit. Deductible does not apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>——————————none——————————</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>Per test, not per visit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a Plan Provider</td>
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<td>----------------------</td>
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<td>----------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$25/prescription</td>
<td>Not Covered</td>
<td>Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs. Rx Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>50% coinsurance after Rx deductible</td>
<td>Not Covered</td>
<td>Up to 30-day or 90-day supply. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% Coinsurance after Rx deductible</td>
<td>Not Covered</td>
<td>Up to 30-day or 90-day supply. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>50% Coinsurance after Rx deductible</td>
<td>Not Covered</td>
<td>Up to a $150 max per 30-day supply, or up to a $300 max per 90-day supply at KP Pharmacy or Mail Order. No charge for oral chemotherapy drugs.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>————none——— ————none———</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>————none——— ————none———</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>30% Coinsurance after deductible</td>
<td>30% Coinsurance after deductible</td>
<td>————none——— ————none———</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge after deductible</td>
<td>No Charge after deductible</td>
<td>Non-licensed ambulance services not covered</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70/visit after deductible</td>
<td>$70/visit after deductible</td>
<td>Non-plan providers are covered only outside the service area.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>————none——— ————none———</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>————none——— ————none———</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a Plan Provider</td>
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<tr>
<td>----------------------</td>
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<td>--------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>$50/visit</td>
<td>Not Covered</td>
<td></td>
<td>Group Therapy is $25/visit. Deductible does not apply. All other Outpatient Services are 30% coinsurance after deductible.</td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>$50/visit</td>
<td>Not Covered</td>
<td></td>
<td>Group Therapy is $25/visit. Deductible does not apply. All other Outpatient Services are 30% coinsurance after deductible.</td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Inpatient: 30% Coinsurance after deductible; Outpatient: $50/visit after deductible</td>
<td>Not Covered</td>
<td></td>
<td>Inpatient: None; Outpatient: PT/OT/ST limit of 30 visits/therapy/condition/yr. Cardiac Rehab limit of 90 visits/therapy/yr. Pulmonary Rehab limit of 1 program/lifetime.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$50/visit after deductible</td>
<td>Not Covered</td>
<td></td>
<td>Limit of 30 visits for adults age 19 and over per year.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td>Limited to 100 days per year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice service</td>
<td>30% Coinsurance after deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Services You May Need</th>
<th>Your cost if you use a Plan Provider</th>
<th>Your cost if you use a Non-Plan Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eye exam</td>
<td>$50/visit</td>
<td>Not Covered</td>
<td>One exam per year. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>No charge (Deductible does not apply)</td>
<td>Not Covered</td>
<td>1 pair glasses/yr (single OR bifocal lenses) OR 1st purchase of contact lenses/yr OR 2 pair/eye/yr medically necessary contacts (select group of frames and contacts)</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>No charge (Deductible does not apply)</td>
<td>Not Covered</td>
<td>Age six and older: 1 set of full mouth x-rays/panoramic film covered every 3 years. No more than 1 set of x-rays are covered per provider within a 3 year period.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** *(This isn’t a complete list. Check your policy or plan document for other excluded services.)*

- Cosmetic Surgery
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services** *(This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)*

- Acupuncture with limits
- Bariatric Surgery
- Chiropractic Care with limits
- Hearing Aids with limits
- Infertility Treatment
- Routine Dental Services (Adult) with limits
- Routine Eye Exam (Adult)
- Routine Hearing Tests
- Voluntary Termination of Pregnancy with limits

### Your Rights to Continue Coverage:
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:
- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area
For more information on your rights to continue coverage, contact the insurer at 800-777-7902. You may also contact your state insurance department at 1-800-492-6116.

**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-866-444-3272

**Does this Coverage Provide Minimum Essential Coverage?**
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services:**
SPANISH (Español): Para obtener asistencia en Español, llame al 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $2,820</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $4,720</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient Pays:**
- Deductibles $4,500
- Copays $20
- Coinsurance $0
- Limits or exclusions $200

**Total** $4,720

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays</strong> $2,220</td>
</tr>
<tr>
<td><strong>Patient pays</strong> $3,180</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient Pays:**
- Deductibles $1,700
- Copays $1,400
- Coinsurance $0
- Limits or exclusions $80

**Total** $3,180

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800-777-7902, TTY/TDD 1-301-879-6380 or 711.
### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

#### Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are **not** cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 the number provided below.
District of Columbia  1-800-777-7902
Maryland            1-800-777-7902
Virginia            1-800-777-7902
TTY                 711

If you believe that Kaiser Health Plan 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 with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser 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 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

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

California ....................... 1-800-464-4000
Colorado ......................... 1-800-632-9700
District of Columbia .......... 1-800-777-7902
Georgia ............................ 1-888-865-5813
Hawaii .............................. 1-800-966-5955
Maryland ......................... 1-800-777-7902
Oregon .............................. 1-800-813-2000
Virginia ............................ 1-800-777-7902
Washington ....................... 1-800-813-2000
TTY ..................................... 711

60436922 National 2016
中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonouomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a enruk pwe kopwe fori pwan ekoch fofo, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonouomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d’inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

Hindi (Hindi): आपके को किसी भी चुकाये आपकी भाषा में सहयोग देने का अधिकार है। यदि आप आपके अवदेहन पत्र के विषय में या Kaiser Permanente के कवरेज के लिये या कुछ दुसरे प्रश्न के लिये जुड़े हो, तो नीचे दिए गए नम्बर पर फोन करके किसी विशेष सचिव को संपर्क करें।
Kajin Majōl (Marshallese): EWor jimwo eo aṁ in bōk jiπaŋ iilo kajin eo aṁ eje̍lōж wōnān. Ñe ewōr aṁ kajitōk kōn peba in aplaiki eo aṁ ak insurance eo aṁ jān Kaiser Permanente, ak fē enaan in kōjelā in ej aikuj bwe kwōn makūtkūt mokta jān juon raan eo emōj an kallikkar, kalōk nōmba eo ej lelōk ŋan state eo aṁ ak jikūn bwe kwōn maroñ kōnono īppo jon juon ri-uïkōt.

Naabeehō (Navajo): T’āā ni nizaad bee nkā i’doowl dool bik’ē asinīlāgōcį́ ē ci bee nāhaz’ā. Kaiser Permanente ākā anā’lwo’ nā bik’ē ažlaadō yinizkēddo naaltsoos hadinila, ē ci bina’i’dild idol dooggo, ē ci doodago dī naaltsoos haa’ida yoolkālgo hai’t’aďa i’diiuí niñignů cį́ nitsaa hahoodzoi ē ci doodago t’āā aadí nahoñ’ā’di ata’ dahanle ‘įgįį bich’į’ hōlne’ go bee bil ahīl hodīlīnih.

Nepalī (Nepali): tōpaisān kūn nul kumbūk āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣāma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn āfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concentrate ē ci kūn Ąfpanā bhāṣǎma sahāyata pa concent