

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-855-249-5005 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.HealthCare.gov/sbc-glossary/](http://www.HealthCare.gov/sbc-glossary/) or call 1-855-249-5005 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	\$5,250 Individual / \$10,500 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Pediatric Dental: \$50 Individual in network. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,850 Individual / \$15,700 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">Balance Billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network providers</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	First 2 visits \$50 copay. Copay not subject to the <a href="#">deductible</a> . 40% <a href="#">coinsurance</a> for services received during a visit after <a href="#">deductible</a> . Visit 3 and thereafter 40% <a href="#">coinsurance</a> .	Not covered	First 2 visits (combined Primary Care, Mental Health, Substance Abuse Disorder).
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Preventive care/ screening/ immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRI's)	40% <a href="#">coinsurance</a>	Not covered	None
<b>If you need drugs to treat your illness or condition</b>  <b>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>.</b>	Generic drugs	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">formulary</a> guidelines. Federally mandated over-the-counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second fill and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Preferred brand drugs	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">formulary</a> guidelines.
	Non-preferred brand drugs	40% <a href="#">coinsurance</a>	Not covered	Must be authorized through the non-preferred drug process.
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a>	Not covered	Subject to <a href="#">formulary</a> guidelines.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Non-participating providers</a> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fee	40% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First 2 visits \$50 copay. Copay not subject to the <a href="#">deductible</a> . 40% <a href="#">coinsurance</a> for services received during a visit after <a href="#">deductible</a> . Visit 3 and thereafter 40% <a href="#">coinsurance</a> .	Not covered	First 2 visits (combined Primary Care, Mental Health, Substance Abuse Disorder). Group visit 50% of individual visit copay.
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	None
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to less than 8 hours per day and 28 hours per week.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year.; Outpatient: Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 100 days per year.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	Prosthetic arms and legs at 20% <a href="#">coinsurance</a> ; not subject to <a href="#">deductible</a> . Coverage is limited to items on our <a href="#">DME formulary</a> .
	<a href="#">Hospice service</a>	No charge	Not covered	Not subject to the <a href="#">deductible</a> .
If your child needs dental or eye care	Children's eye exam	40% <a href="#">coinsurance</a>	Not covered	Limited to members up to the end of the calendar year the member turns 19. Copay not subject to the <a href="#">deductible</a> . For services with an ophthalmologist see " <a href="#">Specialist</a> visit".
	Children's glasses	50% <a href="#">coinsurance</a>	Not covered	1 pair of glasses & lenses every 2 years or 2 year supply of contact lenses. Limited to members up to the end of the calendar year in which the member turns 19. Not subject to the <a href="#">deductible</a> .
	Children's dental check-up	No charge for <a href="#">preventive care</a> / diagnostic services after the pediatric dental <a href="#">deductible</a> . 50% <a href="#">coinsurance</a> for basic/major services after the pediatric dental <a href="#">deductible</a> .	Not covered	Limited to members up to the end of the month the member turns 19; limited coverage for diagnostic and <a href="#">preventive services</a> , minor restorative (fillings), simple extractions and crowns.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Non-Emergency Care when Traveling Outside the U.S.</li> <li>• Routine Eye Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids with limits</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Private-Duty Nursing</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

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

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Colorado Division of Insurance	1-303-894-7490 in state, or 1-800-930-3745 out of state or <a href="http://www.colorado.gov/pacific/dora/division-insurance">www.colorado.gov/pacific/dora/division-insurance</a>

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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

**Language Access Services:**

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-855-249-5005 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5005 (TTY: 711)

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,250	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,250
■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%
■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other (blood work) <a href="#">coinsurance</a>	40%	■ Other (blood work) <a href="#">coinsurance</a>	40%	■ Other (x-ray) <a href="#">coinsurance</a>	40%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Durable medical equipment (<i>crutches</i>)                      Diagnostic test (<i>x-ray</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<b>Cost Sharing</b>		<b>Cost Sharing</b>		<b>Cost Sharing</b>	
Deductibles	\$5250	Deductibles	\$4700	Deductibles	\$1700
Copays	\$0	Copays	\$400	Copays	\$50
Coinsurance	\$2600	Coinsurance	\$300	Coinsurance	\$60
<b>What isn't covered</b>		<b>What isn't covered</b>		<b>What isn't covered</b>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7910</b>	<b>The total Joe would pay is</b>	<b>\$5460</b>	<b>The total Mia would pay is</b>	<b>\$1810</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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## Colorado Supplement to the Summary of Benefits and Coverage Form

<b>INSURANCE COMPANY NAME</b>	Kaiser Foundation Health Plan of Colorado
<b>NAME OF PLAN</b>	KP Select CO Bronze 5250/50
<b>1. Type of Policy</b>	Individual Policy
<b>2. Type of plan</b>	Health maintenance organization (HMO)
<b>3. Areas of Colorado where plan is available.</b>	<p>Plan is available only in the following counties as determined by <b>zip code</b> code and employer service area selection:</p> <ol style="list-style-type: none"> <li>1. <b>For Denver/Boulder service area:</b> Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld;</li> <li>2. <b>For Southern Colorado:</b> Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller;</li> <li>3. <b>For Southern Colorado <i>KP Select Plan</i>:</b> Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller;</li> <li>4. <b>For Northern Colorado:</b> Adams, Larimer, Morgan, and Weld;</li> <li>5. <b>For Mountain Colorado:</b> Eagle, Summit, Garfield, Grand and Routt.</li> </ol>

### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

**Important Note:** The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
<b>4. Annual Deductible Type</b>	<p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.</p>
<b>5. Out-of-Pocket Maximum</b>	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>

<b>6. What is included in the In-Network Out-of-Pocket Maximum?</b>	Deductibles, coinsurance and copayments for Essential Health Benefits.
<b>7. Is pediatric dental covered by this plan?</b>	Yes
<b>8. What cancer screenings are covered?</b>	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

#### USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
<b>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes, members are responsible for any amounts over usual, reasonable and customary charges when receiving Emergency Services and Non-Emergency, Non-Routine Care.
<b>10. Does the plan have a binding arbitration clause?</b>	No	

**Questions:** Call 1-855-249-5005 (TTY 711) or visit us at [www.kp.org](http://www.kp.org).

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD Colorado Springs: 1-800-521-4874 Denver/Boulder: 1-303-338-3820

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance  
Consumer Services, Life and Health Section  
1560 Broadway, Suite 850, Denver, CO 80202  
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)  
Email: [dora\\_insurance@state.co.us](mailto:dora_insurance@state.co.us)

# NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (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 **1-800-632-9700** (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 by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

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>.

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

**አማርኛ (Amharic) ማሰታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

**Bàsòò Wùdù (Bassa) Dè dɛ nià kɛ dyédé gbo:** Ɔ jù ké m̀ Bàsòò-wùdù-po-nyò jù ní, níí, à wuɖu kà kò d̀ò po-poò béìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** (TTY: **711**)。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY: 711).

**Igbo (Igbo) NRUBAMA:** Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijirị gi. Kpọọ **1-800-632-9700** (TTY: 711).

**日本語 (Japanese) 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。 **1-800-632-9700** (TTY:711) まで、お電話にてご連絡ください。

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: 711)번으로 전화해 주십시오.

**Naabeehó (Navajo) Díí baa akó nínízin:** Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kóji' hódíłnih **1-800-632-9700** (TTY: 711).

**नेपाली (Nepali) ध्यान दिनुहोस्:** तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: 711) फोन गर्नुहोस् ।

**Afaan Oromoo (Oromo) XIYYEEFFANNAA:**Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: 711).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: 711).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: 711).

**Tagalog (Tagalog) PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY: 711).

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: 711).

**Yorùbá (Yoruba) AKIYESI:** Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: 711).