
 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 or 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/.com](http://www.HealthCare.gov/sbc-glossary/.com) or call 1-855-249-5005 or TTY 711 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,250 Individual / \$2,500 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 services</a> , services with Copayments, prescription drugs, hospice and pediatric hardware.	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 per person 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> ?	\$4,500 Individual / \$9,000 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> ?	Premiums, balanced-billed charges and health care this plan 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 1-855-249-5005 or TTY 711 for a list of <a href="#">plan providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">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 provider</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		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35 Copayment per visit (10% for other covered services received during a visit)	Not Covered	Copayment not subject to the deductible
	<a href="#">Specialist</a> visit	\$55 Copayment per visit (10% for other covered services received during a visit)	Not Covered	Copayment not subject to the deductible
	<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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org">www.kp.org</a>	Generic drugs	Retail: \$15 Copayment; Mail Order: \$30 Copayment not subject to the deductible	Not Covered	Subject to formulary 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 maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Preferred brand drugs	Retail: \$45 Copayment; Mail Order: \$90 Copayment Copayment not subject to the deductible	Not Covered	Subject to <a href="#">formulary</a> guidelines.
	Non-preferred brand drugs	10% Coinsurance	Not Covered	Must be authorized through the non-preferred drug process. Not subject to the deductible

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	<a href="#">Specialty drugs</a>	10% Coinsurance	Not Covered	Subject to <a href="#">formulary</a> guidelines. Some <a href="#">Specialty drugs</a> are available in other tiers. Not subject to the deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not Covered	None
	Physician/surgeon fees	10% Coinsurance	Not Covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 Copayment per visit	\$400 Copayment per visit	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted directly to the hospital as an inpatient. Copayment not subject to the deductible
	<a href="#">Emergency medical transportation</a>	10% Coinsurance	10% Coinsurance	None
	<a href="#">Urgent care</a>	\$75 Copayment per visit (10% for other covered services received during a visit)	\$75 Copayment per visit (10% for other covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area. Copayment not subject to the deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not Covered	None
	Physician/surgeon fees	10% Coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 Copayment per visit (10% for other covered services received during a visit)	Not Covered	Group visit 50% of individual visit Copayment. Copayment not subject to the deductible
	Inpatient services	10% Coinsurance	Not Covered	None
If you are pregnant	Office visits	10% Coinsurance	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			
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% Coinsurance	Not Covered	Limited to less than 8 hours per day and 28 hours per week.
	<a href="#">Rehabilitation services</a>	\$35 Copayment per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copayment not subject to the deductible
	<a href="#">Habilitation services</a>	\$35 Copayment per visit	Not Covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit). Copayment not subject to the deductible
	<a href="#">Skilled nursing care</a>	10% Coinsurance	Not Covered	Limited to 100 days per year.
	<a href="#">Durable medical equipment</a>	10% Coinsurance	Not Covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs at 10 % coinsurance. Not subject to <a href="#">deductible</a> .
	<a href="#">Hospice services</a>	No Charge	Not Covered	Not subject to the deductible
If your child needs dental or eye care	Children's eye exam	\$35 Copayment per visit (10% for other covered services received during a visit)	Not Covered	Limited to members up to the end of the year in which the member turns 19. For services with an ophthalmologist see "Specialist visit". Copayment not subject to the deductible
	Children's glasses	50% Coinsurance	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 year in which the member turns 19.
	Children's dental check-up	No Charge for preventive / diagnostic services. 50% coinsurance for basic / major services	Not Covered	Limited to members up to the end of the year in which 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 [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Cosmetic Surgery
- Long Term Care/Custodial Nursing Home Care
- Non-emergency care when traveling outside the U.S.
- Routine Dental Services (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids with limits
- Infertility Treatment
- Private-Duty Nursing
- Routine eye care (Adult)

**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: The plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (instate, toll-free: 800-930-3745), or email: [insurance@dora.state.co.us](mailto:insurance@dora.state.co.us).

**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.

See the "Help in your Language" at the end of this Summary of Benefits and Coverage.

-----*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)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist \[copay\]](#) \$55
- Hospital (facility) [\[coinsurance\]](#) 10%
- Other [\[coinsurance\]](#) 10%

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,250
Copayments	\$40
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,450</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist \[copay\]](#) \$55
- Hospital (facility) [\[coinsurance\]](#) 10%
- Other [\[coinsurance\]](#) 10%

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,460</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,250
- [Specialist \[copay\]](#) \$55
- Hospital (facility) [\[coinsurance\]](#) 10%
- Other [\[coinsurance\]](#) 10%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$600
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>

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

**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>	<b>KPCO</b> Gold DHMO Plus 1250.35
<b>1. Type of Policy</b>	Small Employer Group 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 <b>only</b> in the following counties as determined by <b>zip code</b> 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, Garfield, Grand, Routt and Summit.</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.

**INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.** This means if you live or work outside of the service area where this plan is available, you will have to travel into this service area to receive non-emergency or non-urgent covered services.

	<b>Description</b>
<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%.</p>



	<p>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, pediatric dental is subject to a separate \$50 deductible
<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**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>8. 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>9. 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) ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት 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 jũ ké m̀ Bàsòò-wùdù-po-nyò jũ ní, níí, à wudu kà kò dò po-poò bèin m̀ gbo kpáa. Đá **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:** O buru na i na asu Igbo, oru enyemaka asusu, n'efu, diiri gi. **Кроо 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'áa jiiik'eh, éi ná hóló, koji' hódíílnih **1-800-632-9700** (TTY: 711).

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

**Afaan Oromoo (Oromo) XIYYEEFFANNA:** 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).