




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 or call 1- 866-213-3062 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/ or call 1-866-213-3062 or TTY 711 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | \$2,800 Individual / \$5,600 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes, preventive services and services indicated in chart starting on page 2. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| What is the out-of-pocket limit for this plan? | \$4,000 Individual/ \$8,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balanced-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.kp.org or call 1-866-213-3062 or TTY 711 for a list of plan providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |

 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 |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 30% Coinsurance | Not Covered | None |
| | Specialist visit | 30% Coinsurance | Not Covered | None |
| | Preventive care/screening / immunization | No Charge, deductible does not apply | Not Covered | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-ray: 30% Coinsurance Lab: 30% Coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% Coinsurance | Not Covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org | Generic drugs | Retail: \$20 Copay; Mail Order: \$40 Copay | Not Covered | Subject to formulary guidelines. Preventive Drugs on the KP Preventive Drug list at No Charge. Non-preferred brand drugs must be authorized through the non-preferred drug process. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs | Retail: \$40 Copay; Mail Order: \$80 Copay | Not Covered | |
| | Non-preferred brand drugs | Retail: \$60 Copay; Mail Order: \$120 Copay | Not Covered | |
| | Specialty drugs | 30% Coinsurance | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance | Not Covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 30% Coinsurance | Not Covered | None |
| If you need immediate medical attention | Emergency room care | 30% Coinsurance | 30% Coinsurance | None |
| | Emergency medical transportation | 30% Coinsurance | 30% Coinsurance | None |
| | Urgent care | 30% Coinsurance | 30% Coinsurance | Non-Plan providers covered when temporarily outside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% Coinsurance | Not Covered | None |
| | Physician/surgeon fees | 30% Coinsurance | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 30% Coinsurance | Not Covered | None |
| | Inpatient services | 30% Coinsurance | Not Covered | None |
| If you are pregnant | Office visits | 30% Coinsurance | Not Covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 30% Coinsurance | Not Covered | None |
| | Childbirth/delivery facility services | 30% Coinsurance | Not Covered | None |
| If you need help recovering or have other special health needs | Home health care | 30% Coinsurance | Not Covered | Limited to less than 8 hours / day and 28 hours / week. |
| | Rehabilitation services | Inpatient services: 30% Coinsurance Outpatient services: 30% Coinsurance | Not Covered | Inpatient: Multi-disciplinary facility limited to 60 days / condition / year. Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). |
| | Habilitation services | 30% Coinsurance | Not Covered | Outpatient: 60 visit limit / therapy year (autism spectrum disorders are not subject to the visit limit). |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | 30% Coinsurance | Not Covered | 100 day limit / year. |
| | Durable medical equipment | 30% Coinsurance | Not Covered | Subject to formulary guidelines. Prosthetic arms and legs at 20% Coinsurance. |
| | Hospice services | 30% Coinsurance | Not Covered | None |
| If your child needs dental or eye care | Children’s eye exam | 30% Coinsurance for refractive exam | Not Covered | For services with an ophthalmologist see “Specialist visit”. |
| | Children’s glasses | Not Covered | Not Covered | None |
| | Children’s dental check-up | Not Covered | Not Covered | None |

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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic Surgery • Dental care (Adult and child) | <ul style="list-style-type: none"> • Infertility treatment • Long Term Care/Custodial Nursing Home Care • Non-emergency care when traveling outside the US | <ul style="list-style-type: none"> • 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.) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Chiropractic care • Hearing aids (Up to age 18) | <ul style="list-style-type: none"> • Private Duty Nursing | <ul style="list-style-type: none"> • 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 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 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 on how 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 agencies in the chart below:

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

| | |
|--|---|
| Self-Funded Customer Service | 1-800-788-0710 (TTY: 711) |
| Department of Labor's Employee Benefits Security Administration | 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or www.cciio.cms.gov |

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 1-866-213-3062 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-213-3062 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-213-3062 (TTY: 711)

Your health benefits will be self-insured by your [Plan](#) Sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the [Plan](#) and will not be an insurer of the [Plan](#) or financially liable for health care benefits under the [Plan](#).

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](#) \$2,800
- [Specialist Coinsurance](#) 30%
- Hospital (facility) [Coinsurance](#) 30%
- Other [Coinsurance](#) 30%

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$1,200 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,060 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,800
- [Specialist Coinsurance](#) 30%
- Hospital (facility) [Coinsurance](#) 30%
- Other [Coinsurance](#) 30%

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$200 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,120 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,800
- [Specialist Coinsurance](#) 30%
- Hospital (facility) [Coinsurance](#) 30%
- Other [Coinsurance](#) 30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,400 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |

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

Colorado Supplement to the Summary of Benefits and Coverage Form

| | |
|--|---|
| INSURANCE COMPANY NAME | Kaiser Foundation Health Plan of Colorado |
| NAME OF PLAN | Denver Public Schools HDHP 2800 EMB 30% |
| 1. Type of Policy | Large Employer Group Policy |
| 2. Type of plan | Health maintenance organization (HMO) |
| 3. Areas of Colorado where plan is available. | <p>Plan is available only in the following counties as determined by zip code:</p> <p>Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld</p> <p>KP Select Plan: Douglas, El Paso, Elbert, Fremont, Lincoln, Park, Pueblo and Teller</p> |

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 |
|----------------------------------|---|
| 4. Annual Deductible Type | <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> |
| 5. Out-of-Pocket Maximum | <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> |

| | |
|---|--|
| 6. What is included in the In-Network Out-of-Pocket Maximum? | Deductibles, coinsurance and copayments. |
| 7. Is pediatric dental covered by this plan? | No, the plan does not include pediatric dental. |
| 8. What cancer screenings are covered? | 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 |
|---|-------------------|---|
| 9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference? | No | Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility. |
| 10. Does the plan have a binding arbitration clause? | No | |

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

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

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY 711).

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al 711).

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

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC 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: **1-866-213-3062** (TTY: **711**)

If you believe that KPIC 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 or phone at: KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd, Canfield OH 44406, telephone number 1-866-213-3062.

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-866-213-3062** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-866-213-3062** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-213-3062** (TTY: **711**).

Հայերեն (Armenian): Ուիշարուհիները եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք **1-866-213-3062** (TTY **711**):

Bàsóò Wùdù (Bassa) Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ Bàsóò-wùdù-po-nyò jũ ní, níí, à wuɖu kà kò dò po-poò b̀éìn m̀ gbo kpáa. Đá **1-866-213-3062** (TTY: 711)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-213-3062** تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-213-3062** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-213-3062** (TTY: 711).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-866-213-3062** (TTY: 711).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-213-3062** (TTY: 711).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-866-213-3062** (TTY: 711) पर कॉल करें।

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, uas pab dawb rau koj. Hu rau **1-866-213-3062** (TTY: 711).

Igbo (Igbo) NRUBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijirị gi. Kpọọ **1-866-213-3062** (TTY: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-213-3062** (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。 **1-866-213-3062** (TTY: 711) まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-866-213-3062** (TTY: 711)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-213-3062** (TTY: 711) 번으로 전화해 주십시오.

ລາວ (Laotian) ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ **1-866-213-3062** (TTY: 711).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yánífti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jii'eh, éí ná hóló, koji' hódíílnih **1-866-213-3062** (TTY: 711).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । **1-866-213-3062** (TTY: 711) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-866-213-3062** (TTY: 711).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-213-3062** (TTY: 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-866-213-3062** (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-866-213-3062** (TTY: 711).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-213-3062** (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-866-213-3062** (TTY: 711).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-866-213-3062** (TTY: 711).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **1-866-213-3062** (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 **1-866-213-3062** (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 **1-866-213-3062** (TTY: 711).