



: [KPLF 3500 / 20% / 6500](#)

Coverage for: Individual / Family | [Plan](#) Type: Ded EPO



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 <https://levelfunded.kaiserpermanente.org/> or call 1-800-401-8405 (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 1-800-401-8405 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,500 Individual / \$7,000 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 beginning 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?	No	You don't have to meet <a href="#">deductibles</a> for specific services
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,500 Individual / \$13,000 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> ?	<a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart beginning on page 2.	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 1-800-401-8405 (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 <a href="#">plan's 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 <a href="#">provider's</a> 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> ?	Yes, but you may self-refer to some <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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
		<a href="#">Plan Provider</a> (You will pay the least)	<a href="#">Non-Plan Provider</a> (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 / visit, <a href="#">deductible</a> does not apply	Not covered	Virtual care services: No charge, <a href="#">deductible</a> does not apply
	<a href="#">Specialist</a> visit	\$50 / visit, <a href="#">deductible</a> does not apply	Not covered	Virtual care services: No charge, <a href="#">deductible</a> does not apply
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	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 needed are <a href="#">preventive</a> . 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)	20% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$300 / test, <a href="#">deductible</a> does not apply	Not covered	None
<b>If you need drugs to treat your illness or condition</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>	Generic drugs	\$15 retail and \$30 mail order / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order). No charge for contraceptives, <a href="#">deductible</a> does not apply.
	Preferred brand drugs	\$50 retail and \$100 mail order / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order).
	Non-preferred drugs	\$75 retail and \$150 mail order / <a href="#">prescription</a> , <a href="#">deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order).
	<a href="#">Specialty drugs</a>	\$500 retail, <a href="#">deductible</a> does not apply	Not covered	Subject to <a href="#">formulary</a> guidelines, when approved through the exception process. Up to a 30-day supply (retail).
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 / visit, <u>deductible</u> does not apply	\$500 / visit, <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$100 / visit, <u>deductible</u> does not apply	Not covered	<u>Non-Plan providers</u> covered when temporarily outside the service area at \$100 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit, <u>deductible</u> does not apply	Not covered	\$15 / group visit, <u>deductible</u> does not apply. Virtual care services: No charge, <u>deductible</u> does not apply
	Inpatient services	20% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include test and services described elsewhere in the SBC (i.e.ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	Limited to 120 days / year
	<a href="#">Rehabilitation services</a>	Outpatient: \$30 / visit, <a href="#">deductible</a> does not apply; Inpatient: 20% <a href="#">coinsurance</a>	Not covered	Outpatient: Limited to 20 visits / therapy / year ( <a href="#">Rehabilitation services</a> for autism spectrum disorders are not subject to the visit limit). Virtual care services: No charge, <a href="#">deductible</a> does not apply. Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.
	<a href="#">Habilitation services</a>	\$30 / visit, <a href="#">deductible</a> does not apply	Not covered	Limited to 20 visits / therapy / year ( <a href="#">Habilitation services</a> for autism spectrum disorders are not subject to the visit limit). Virtual care services: No charge, <a href="#">deductible</a> does not apply.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	Limited to 100 days / year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	Not covered	Coverage is limited to items on our DME <a href="#">formulary</a> .
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	\$30 / visit, <a href="#">deductible</a> does not apply	Not covered	None
	Children's glasses	20% <a href="#">coinsurance</a>	Not covered	One pair of eyeglass lenses per calendar year for members up to age 18.
	Children's dental check-up	Not covered	Not covered	None

**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>• Bariatric surgery</li> <li>• Children's eyeglass frames and contacts</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult &amp; child)</li> <li>• Infertility treatment</li> <li>• Long term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <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 [plan](#) document.)**

- Hearing aids (Up to age 18, up to \$1,500 / 24 months)
- 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](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 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:**

Kaiser Permanente Member Services	1-800-788-0710
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.ebsa.healthreform">www.dol.ebsa.healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>

**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)

Traditional 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)

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf at 1-866-213-3062 (TTY: 711) uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni at 1-866-213-3062 (TTY: 711)

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye at 1-866-213-3062 (TTY: 711)

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang at 1-866-213-3062 (TTY: 711)

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

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](#).

## 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](#) \$3,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,800
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$5,310</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,400</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$50
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,750</b>

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

## HELP IN YOUR LANGUAGE:

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal and state civil rights law and does not discriminate or exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expressions, and sex stereotypes), religion, creed or marital status.

### KPIC

- Provides no cost auxiliary 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, braille and accessible electronic formats
- Provides 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**)

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

**አማርኛ (Amharic) ማሳሰቢያ:-** አማርኛ የሚናገሩ ከሆነ፣ ተገቢ የሆኑ ረዳት መርጃዎች እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ለእርስዎ ይገኛሉ። ወደ **1-866-213-3062** (TTY: **711**) ይደውሉ።

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

**Հայերեն (Armenian) Ուշադրություն:** եթե հայերեն եք խոսում, ձեզ համար մատչելի են լեզվական աջակցության անվճար ծառայություններ, ներառյալ համապատասխան օժանդակ միջոցներ և ծառայություններ: Չանգահարեք **1-866-213-3062** հեռախոսահամարով (TTY **711**):

**Bàsɔ-Wùdù (Bassa) DYÉDÉ-GBO-DE-ÐÉ:** ɔ jũ ké m̄ dyi Bàsɔ-Wùdù po-nyò jũin, wuɖu-xwíníín mú zàz bě kè gbo-kpá-kpá ɔ kè kùà tòò bě se wídí. pɛ̀è-pɛ̀è d̀ò k̀ɛ̀ɛ̀ nì bó m̄ bìì. Ðá **1-866-213-3062** (TTY: **711**).

**বাংলা (Bengali) মনোযোগ দিন:** আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনি প্রয়োজনীয় সহায়ক উপকরণ ও সেবা, সহ ভাষা পরিষেবা বিনামূল্যে পেতে পারেন। কল 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協助服務，包括適當的輔助與服務。請致電**1-866-213-3062** (TTY: **711**)。

**فارسی (Farsi) توجه:** اگر به زبان فارسی صحبت می‌کنید خدمات کمکرسانی زبانی، شامل کمک‌ها و خدمات جانبی مناسب، به صورت رایگان در دسترس‌تان قرار می‌گیرد. با شماره **1-866-213-3062** تماس بگیرید (TTY: 711).

**Français (French) ATTENTION :** si vous parlez français, des services d'assistance linguistique, notamment des aides et des services auxiliaires adaptés, sont mis gratuitement à votre disposition. Appelez le **1-866 213-3062** (TTY : 711).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Bitte wählen Sie die **1-866-213-3062** (TTY: 711).

**ગુજરાતી (Gujarati) ध्यान राખो:** જો તમે ગુજરાતી બોલતા હોવ, તો યોગ્ય સહાયક સહાય અને સેવાઓ, સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૉલ કરો **1-866-213-3062** (TTY: 711).

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale kreyòl ayisyen, gen sèvis asistans lengwistik ansanm ak èd epi sèvis ki gen rapò ak sa yo, ki disponib pou ou san w p ap peye. Rele **1-866-213-3062** (TTY: 711).

**हिंदी (Hindi) ध्यान दें:** अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ्त 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) Gee ntị:** O buru na ina-asu asusu Igbo, oru enyemaka asusu gunyere oru na enyemaka kwesiri ekwesị, di n'efu, di maka gi. Kpoo **1-866-213-3062** (TTY: 711).

**Italiano (Italian) ATTENZIONE:** Se parla italiano, può usufruire gratuitamente dei servizi di assistenza linguistica compresi gli opportuni aiuti e servizi ausiliari. Chiami il numero **1-866-213-3062** (TTY: 711).

**日本語 (Japanese) お知らせ :** 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。電話 : **1-866-213-3062** (TTY: 711)。

**ខ្មែរ (Khmer) សូមយកចិត្តទុកដាក់:** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសា រួមទាំងឧបករណ៍ និងសេវាកម្មជំនួយសមរម្យ ដោយមិនគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរសព្ទទៅលេខ **1-866-213-3062** (TTY: 711)។

**한국어 (Korean) 참고:** 한국어를 구사하시는 경우, 필요한 보조 기기와 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-866-213-3062**(TTY: 711)번으로 전화하십시오.

**ພາສາລາວ (Laotian) ໝາຍເຫດ:** ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງຄວາມຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມທຶກງ່າຍໆໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ **1-866-213-3062** (TTY: **711**).

**Naabeehó (Navajo) BEE ADIIT'ÁNÍ:** T'áá shoodí éí Diné bizaad bee yániłti', t'áá iiyisí dóó ch'iyáán yáhoot'éeł nihá shikaadeéł dah naashá. Doo baa akót'éego nihá baąh daniidłį́'. Háálá **1-866-213-3062** (TTY: **711**).

**नेपाल (Nepali) ध्यान दिनुहोस्:** यदि तपाईं नेपाली बोल्नुहुन्छ भने उपयुक्त सहायक साधनहरू र सेवाहरू सहितको भाषा सहायता सेवा तपाईंको लागि निःशुल्क उपलब्ध छ। **1-866-213-3062** (TTY: **711**) मा फोन गर्नुहोस्।

**Afaan Oromoo (Oromo) FUULEFFANNAA:** Afaan Oromoo dubbattu yoo ta'e, tajaajiloonni afaanii meeshaalee fi tajaajiloota qaama miidhamtootaaf mijaa'oo ta'an dabalatee, kaffaltii irraa bilisa karaa ta'een, ni argamu. Bilbilaa **1-866-213-3062** irratti (TTY: **711**).

**Português (Portuguese) ATENÇÃO:** Se você fala português, serviços de assistência de idioma, incluindo recursos e serviços auxiliares adequados, estão disponíveis gratuitamente para você. Ligue para **1-866-213-3062** (TTY: **711**).

**ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ:** ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਢੁਕਵੇਂ ਸਹਾਇਕ ਉਪਕਰਨਾਂ ਸਮੇਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। **1-866-213-3062** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

**Română (Romanian) ATENȚIE:** Dacă vorbiți limba română, vă sunt disponibile în mod gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la numărul **1-866-213-3062** (TTY: **711**).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите по-русски, вы можете получить бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Звоните по телефону **1-866-213-3062** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen aparatos y servicios auxiliares adecuados y gratuitos. Llame al **1-866-213-3062** (TTY: **711**).

**Tagalog (Tagalog) PAUNAWA:** Kung kayo ay nagsasalita ng Tagalog, ang mga serbisyo ng tulong sa wika, kabilang ang mga naaangkop na karagdagang tulong at serbisyo, na walang bayad, ay available sa inyo. Tumawag sa **1-866-213-3062** (TTY: **711**).

**ไทย (Thai) หมายเหตุ:** หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โปรดติดต่อหมายเลข **1-866-213-3062** (เครื่อง TTY: **711**)

**Українська (Ukrainian) УВАГА!** Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Телефонуйте **1-866-213-3062** (TTY: **711**).

**اردو (Urdu) توجہ دیں:** اگر آپ اردو بولتے ہیں تو لسانی اعانت کی خدمات، بشمول مناسب معاون امدادی آلات اور خدمات، بلا معاوضہ، آپ کے لیے دستیاب ہیں۔ **1-866-213-3062** (TTY: **711**) پر کال کریں۔

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu nói tiếng Việt, quý vị có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Gọi số **1-866-213-3062** (TTY: **711**).

**Yorùbá (Yoruba) ÀKÍYÈSÍ:** Bí o bá lè sọ èdè Yorùbá, àwọn ètò iránlọwọ èdè, tí tí kan àwọn ohun èlò àti isẹ iránlọwọ tó yẹ wà fún ọ lófèè. Pe **1-866-213-3062** (TTY: **711**).

## NONDISCRIMINATION NOTICE:

If you believe that KPIC has failed to provide these services or discriminated in another way on the basis of national origin, ancestry, age, disability, sex, religion, creed, or marital status, you can file a grievance by mail or phone with your home region Civil Rights Coordinator office:

<b>Colorado</b>	<b>Georgia</b>	<b>Northwest</b>
KPIC Civil Rights Coordinator PO Box 378066 Denver, CO 80237-8066  Fax: 1-866-466-4042 Phone: 1-855-364-3184	KPIC Civil Rights Coordinator Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736  Fax: 1-404-949-5001 Phone: 1-855-364-3185	KPIC Civil Rights Coordinator 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099  Fax: 1-855-347-7239 Phone: 1-866-616-0047
<b>California</b>	<b>Mid-Atlantic (DC, MD, VA)</b>	<b>Washington</b>
KPIC Civil Rights Coordinator PO Box 1809 Pleasanton, CA 94566  Fax: 1-888-987-2252 Phone: 1-800-788-0710	KPIC Civil Rights Coordinator PO Box 1809 Pleasanton, CA 94566  Fax: 1-888-987-2252 Phone: 1-800-788-0710	KPIC Civil Rights Coordinator P.O. Box 34593 Seattle, WA 98124-1593  Fax: 1-206-630-1859 Phone: 1-866-458-5479

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- By completing the complaint form and submitting the form to:

The U.S. Department of Health and Human Services  
200 Independence Avenue SW, Room 509F, HHH Building  
Washington, DC 20201  
Phone: 1-800-368-1019  
Phone (TDD): 1-800-537-7697

Complaint forms can be found online:  
<http://www.hhs.gov/ocr/office/file/index.html>.

- Or, electronically by submitting your complaint through the Office for Civil Rights Complaints Online Portal:  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>