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 or call 1-800-401-8405 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 Individual / $1,500 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 care and services indicated in chart beginning 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
What is the out-of-pocket limit for this plan?	$3,000 Individual / $6,000 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, health care this plan doesn't cover, and services indicated in chart beginning on page 2.	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 1-800-401-8405 (TTY: 711) for a list of network 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?	Yes, but you may self-refer to some specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit, deductible does not apply	Not covered	Virtual care services: No charge, deductible does not apply
	Specialist visit	$25 / visit, deductible does not apply	Not covered	Virtual care services: No charge, deductible does not apply
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	$200 / test, deductible does not apply	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/formulary	Generic drugs	$5 retail and $10 mail order / prescription, deductible does not apply	Not covered	Subject to formulary guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order). No charge for contraceptives, deductible does not apply.
	Preferred brand drugs	$30 retail and $60 mail order / prescription, deductible does not apply	Not covered	Subject to formulary guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order).
	Non-preferred drugs	$45 retail and $90 mail order / prescription, deductible does not apply	Not covered	Subject to formulary guidelines. Up to a 30-day supply (retail). Up to a 90-day supply (mail order).
	Specialty drugs	$500 retail, deductible does not apply	Not covered	Subject to formulary guidelines, when approved through the exception process. Up to a 30-day supply (retail).
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

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 immediate medical attention	Emergency room care	$300 / visit, deductible does not apply	$300 / visit, deductible does not apply	Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$50 / visit, deductible does not apply	Not covered	Non-Plan providers covered when temporarily outside the service area at $50 / visit.
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	$15 / visit, deductible does not apply	Not covered	$7 / group visit, deductible does not apply. Virtual care services: No charge, deductible does not apply
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Maternity care may include test and services described elsewhere in the SBC (i.e.ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	None
	Childbirth/delivery facility services	10% coinsurance	Not covered	None

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	Home health care	10% coinsurance	Not covered	Limited to 120 days / year
	Rehabilitation services	Outpatient: $15 / visit, deductible does not apply; Inpatient: 10% coinsurance	Not covered	Outpatient: Limited to 20 visits / therapy / year (Rehabilitation services for autism spectrum disorders are not subject to the visit limit). Virtual care services: No charge, deductible does not apply. Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.
	Habilitation services	$15 / visit, deductible does not apply	Not covered	Limited to 20 visits / therapy / year (Habilitation services for autism spectrum disorders are not subject to the visit limit). Virtual care services: No charge, deductible does not apply.
	Skilled nursing care	10% coinsurance	Not covered	Limited to 100 days / year
	Durable medical equipment	10% coinsurance, deductible does not apply	Not covered	Coverage is limited to items on our DME formulary.
	Hospice services	No charge, deductible does not apply	Not covered	None
If your child needs dental or eye care	Children's eye exam	$15 / visit, deductible does not apply	Not covered	None
	Children's glasses	10% coinsurance	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Children's eyeglass frames and contacts
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & child)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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.)	
• 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 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 www.dol.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)
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-213-3062 (TTY: 711)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-213-3062 (TTY: 711)
Pennsylvania Dutch (Deitsch): Fer Hilf griege 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, å'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	**$750**
Specialist copayment	**$25**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,960**

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

The plan's overall deductible	**$750**
Specialist copayment	**$25**
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$880**

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

The plan's overall deductible	**$750**
Specialist copayment	**$25**
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,210**

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።

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

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

Ɓăsɔ-Wùɖù (Bassa) DYÉĐÉ-GBO-DÈ-ĐÈ: Ɔ jǔ ké m̀ dyi Ɓăsɔ-Wùɖù po-nyɔ̀ jǔìn, wuɖu-xwíníín mú zàz ɓě kè gbo-kpá-kpá ɔ kè kǔà tɔ̀ɔ ɓě se wíɖí. péè-péè ɖò kɔ̃ɛɛ nì ɓó m̀ bìì. Đá **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 Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Bitte wählen Sie die **1-866-213-3062** (TTY: **711**).

ગુજરાતી (Gujarati) ધ્યાન રાખો: 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 मुफ़्त 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 bụrụ na ịna-asụ asụsụ Igbo, ọrụ enyemaka asụsụ gụnyere ọrụ na enyemaka kwesịrị ekwesị, dị n'efu, dị maka gị. Kpọọ **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 ບໍລິການເສີມທີ່ກ່ຽວຂ້ອງໂດຍບໍ່ເສຍຄ່າ. ໂທຫາ **1-866-213-3062** (TTY: **711**).

Naabeehó (Navajo) BEE ADIIT'ÁNÍ: T'áá shoodí éí Diné bizaad bee yáníłti', t'áá iiyisí dóó ch'iyáán yáhoot'éél nihá shikaadéél dah naashá. Doo baa akót'éego nihá bąąh daniidlį́į'. 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 ਮੁਫ਼ਤ 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 иуслуги. 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**).

اُردو(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۔ **1-866-213-30621** (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 ìrànlọ́wọ́ èdè, títí kan àwọn ohun èlò àti iṣẹ́ ìrànlọ́wọ́ tó yẹ wà fún ọ lọ́fẹ̀ẹ́. 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:

Colorado	**Georgia**	**Northwest**
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
California	**Mid-Atlantic (DC, MD, VA)**	**Washington**
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