



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. Please read the FEHB Plan brochure (RI 73-019) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-855-249-5005 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. When a covered service/supply is subject to a <u>deductible</u> , only the Plan allowance for the service/supply counts toward the <u>deductible</u> . If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive services</u> , certain services with copays, prescription drugs and hospice.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> 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 / person up to \$8,000 / family	The <u>out-of-pocket limit</u> , or catastrophic maximum, 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.kp.org/feds or call 1-855-249-5005 (TTY: 711) for a list of plan providers .	This plan uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes , but you may self-refer to certain <u>specialists</u> .	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not covered	You pay \$100 for drugs administered in connection with your care.
	<u>Specialist</u> visit	\$30 / visit	Not covered	You pay \$100 for drugs administered in connection with your care.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$125 / procedure per body part	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary	Preferred generic drugs	\$15 (retail); \$30 (mail order) / <u>prescription</u>	Not covered	Up to 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines. 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. Federally mandated over the counter items are covered with a prescription. No charge for women's <u>preventive</u> contraceptives, in accordance with <u>formulary</u> guidelines.
	Preferred brand drugs	\$40 (retail); \$80 (mail order) / <u>prescription</u>	Not covered	
	Non-preferred drugs	\$60 (retail); \$120 (mail order) / <u>prescription</u>	Not covered	Up to 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines. 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. Must be authorized through the exception drug process.
	<u>Specialty drugs</u>	\$100 (retail) / <u>prescription</u>	Not covered	Up to 30-day supply (retail). Subject to <u>formulary</u> guidelines.

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, plus you may be balance billed)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 / surgery	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	\$300 / visit	\$300 / visit	<u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	\$150 / trip	\$150 / trip	None
	<u>Urgent care</u>	\$30 / visit	\$30 / visit	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / day up to \$1,000 maximum per admission	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / individual visit	Not covered	\$10 / group visit
	Inpatient services	\$500 / day up to \$1,000 maximum per admission	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$500 / day up to \$1,000 maximum per admission	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$20 / visit Rehabilitation facility: \$500 / day up to \$1,000 maximum per admission	Not covered	Outpatient: 20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.

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, plus you may be balance billed)	
	<u>Habilitation services</u>	\$20 / visit	Not covered	20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit).
	<u>Skilled nursing care</u>	No charge	Not covered	100 day limit / year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	Subject to <u>formulary</u> guidelines.
	<u>Hospice services</u>	No charge for home-based; \$500 / day up to \$1,000 maximum per admission	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$20 / visit	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 FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Eyeglasses • Long-term care 	<ul style="list-style-type: none"> • Private-duty nursing • Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (20 visit limit / year) • Habilitation 	<ul style="list-style-type: none"> • Hearing aids (Up to age 18) • Infertility treatment • Non-emergency care when traveling outside of the U.S. See the FEHB Plan Brochure for information. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-855-249-5005 (TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, “How you get care,” and Section 8 “The disputed claims process,” in your FEHB Plan brochure. If you need assistance, you can contact: 1-855-249-5005 (TTY: 711).

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 1-855-249-5005 (TTY: 711).

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

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

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

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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other (blood work) <u>coinsurance</u>	0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other (blood work) <u>coinsurance</u>	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$800

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>copayment</u>	\$500
■ Other (x-ray) <u>coinsurance</u>	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$640



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This is only a summary. Please read the FEHB Plan brochure (RI 73-019) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-855-249-5005 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$150 / Self Only \$300 / Self Plus One \$300 / Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. When a covered service/supply is subject to a deductible , only the Plan allowance for the service/supply counts toward the deductible . 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 , certain services with copays, prescription drugs	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 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?	\$5,500 / person up to \$11,000 / family	The out-of-pocket limit , or catastrophic maximum, 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 , balance-billing charges, 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/feds or call 1-855-249-5005 (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?	Yes , but you may self-refer to certain 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
		<u>Plan Provider</u> (You will pay the least)	<u>Non-Plan Provider</u> (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 / visit; <u>deductible</u> does not apply.	Not covered	Copayment waived for children through age 17. You pay \$200 for drugs administered in connection with your care.
	<u>Specialist</u> visit	\$40 / visit; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for procedures received during a visit.	Not covered	You pay \$200 for drugs administered in connection with your care.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge; <u>deductible</u> does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$150 / procedure per body part	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.kp.org/formulary	Preferred generic drugs	\$15 (retail); \$30 (mail order) / <u>prescription</u> ; <u>deductible</u> does not apply.	Not covered	Preventive maintenance: \$5 (retail); \$10 (mail order) / prescription; <u>deductible</u> does not apply. Up to 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines. 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. Federally mandated over the counter items are covered with a prescription. No charge, <u>deductible</u> does not apply for women's <u>preventive</u> contraceptives, in accordance with <u>formulary</u> guidelines.
	Preferred brand drugs	\$50 (retail); \$100 (mail order) / <u>prescription</u> ; <u>deductible</u> does not apply.	Not covered	
	Non-preferred drugs	\$70 (retail); \$140 (mail order) / <u>prescription</u> ; <u>deductible</u> does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <u>formulary</u> guidelines. Prescriptions for second fill and maintenance medications must be filled at a pharmacy in a Kaiser Permanente medical office or through Kaiser

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, plus you may be balance billed)	
				Permanente mail order. Must be authorized through the exception drug process.
	<u>Specialty drugs</u>	\$200 (retail) / <u>prescription</u> ; <u>deductible</u> does not apply.	Not covered	Up to 30-day supply (retail). Subject to <u>formulary</u> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / surgery	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need immediate medical attention	Emergency room care	\$350 / visit	\$350 / visit	<u>Copayment</u> waived if admitted directly to the hospital as an inpatient.
	<u>Emergency medical transportation</u>	\$200 / trip; <u>deductible</u> does not apply.	\$200 / trip; <u>deductible</u> does not apply.	None
	<u>Urgent care</u>	\$40 / visit; <u>deductible</u> does not apply.	\$40 / visit; <u>deductible</u> does not apply.	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 per admission	Not covered	None
	Physician/surgeon fees	Included in Facility fee	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / individual visit; <u>deductible</u> does not apply.	Not covered	\$15 / group visit; <u>deductible</u> does not apply. <u>Copayment</u> waived for children through age 17.
	Inpatient services	\$750 per admission	Not covered	None
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply.	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	No charge; <u>deductible</u> does not apply.	Not covered	None
	Childbirth/delivery facility services	No charge; <u>deductible</u> does not apply.	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, plus you may be balance billed)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$30 / visit; <u>deductible</u> does not apply. Inpatient: \$750 per admission	Not covered	Outpatient: 20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.
	<u>Habilitation services</u>	\$30 / visit; <u>deductible</u> does not apply.	Not covered	20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit).
	<u>Skilled nursing care</u>	No charge	Not covered	100 day limit / year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> ; <u>deductible</u> does not apply.	Not covered	Subject to <u>formulary</u> guidelines.
	<u>Hospice services</u>	Home based: No charge; Inpatient: 10% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$30 / visit; <u>deductible</u> does not apply.	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 FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care 	<ul style="list-style-type: none"> Eyeglasses Long-term care 	<ul style="list-style-type: none"> Private-duty nursing Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care (20 visit limit / year) Habilitation 	<ul style="list-style-type: none"> Hearing aids (Up to age 18) Infertility treatment Non-emergency care when traveling outside of the U.S. See the FEHB Plan Brochure for information. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 855-249-5005 (TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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.

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Does this plan provide Minimum Essential Coverage? Yes

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

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

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

—————*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 <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$0
■ Other (blood work) <u>coinsurance</u>	0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$750
■ Other (blood work) <u>coinsurance</u>	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$900

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$150
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$750
■ Other (x-ray) <u>coinsurance</u>	0%

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	\$150
Copayments	\$500
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$690



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. Please read the FEHB Plan brochure (RI 73-019) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.kp.org/feds, and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 1-855-249-5005 (TTY: 711) to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 / Self Only \$1,000 / Self Plus One \$1,000 / Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. When a covered service/supply is subject to a deductible , only the Plan allowance for the service/supply counts toward the deductible . 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 , certain services with copays, prescription drugs	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 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?	\$6,500 / person up to \$13,000 / family	The out-of-pocket limit , or catastrophic maximum, 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 , balance-billing charges, 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/feds or call 1-855-249-5005 (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?	Yes , but you may self-refer to certain 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, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 / visit; <u>deductible</u> does not apply. 20% <u>coinsurance</u> for procedures received during a visit.	Not covered	You pay \$300 for drugs administered in connection with your care.
	<u>Specialist</u> visit	\$35 / visit; <u>deductible</u> does not apply. 20% <u>coinsurance</u> for procedures received during a visit.	Not covered	You pay \$300 for drugs administered in connection with your care.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: 20% <u>coinsurance</u> ; Lab: No charge, <u>deductible</u> does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	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, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Preferred generic drugs	\$15 (retail); \$30 (mail order) / prescription; <u>deductible</u> does not apply.	Not covered	Preventive maintenance: \$5 (retail); \$10 (mail order) / prescription; <u>deductible</u> does not apply. Up to 30-day supply (retail) or 90-day supply (mail order). Subject to <u>formulary</u> guidelines. 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. Federally mandated over the counter items are covered with a prescription. No charge, <u>deductible</u> does not apply for women's <u>preventive</u> contraceptives, in accordance with <u>formulary</u> guidelines.
	Preferred brand drugs	\$60 (retail); \$120 (mail order) / prescription; <u>deductible</u> does not apply.	Not covered	
	Non-preferred drugs	\$80 (retail); \$160 (mail order) / prescription; <u>deductible</u> does not apply.	Not covered	
	<u>Specialty drugs</u>	\$300 (retail) / prescription; <u>deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>None</u>
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> up to \$500 / trip; <u>deductible</u> does not apply.	20% <u>coinsurance</u> up to \$500 / trip; <u>deductible</u> does not apply.	None
	<u>Urgent care</u>	\$35 / visit; <u>deductible</u> does not apply.	\$35 / visit; <u>deductible</u> does not apply.	<u>Non-Plan providers</u> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	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, plus you may be balance billed)	
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 / individual visit; <u>deductible</u> does not apply.	Not covered	\$5 / group visit; <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	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Rehabilitation services</u>	Outpatient: \$10 / visit, <u>deductible</u> does not apply. Inpatient: 20% <u>coinsurance</u>	Not covered	Outpatient: 20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit). Inpatient: Multi-disciplinary facility limited to 60 days / condition / year.
	<u>Habilitation services</u>	\$10 / visit; <u>deductible</u> does not apply.	Not covered	20 visit limit / therapy / year (autism spectrum disorders are not subject to the visit limit).
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	100 day limit / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply.	Not covered	Subject to <u>formulary</u> guidelines.
	<u>Hospice services</u>	Home based: No charge; Inpatient: 20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$10 / visit; <u>deductible</u> does not apply.	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 FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care	<ul style="list-style-type: none">• Eyeglasses• Long-term care	<ul style="list-style-type: none">• Private-duty nursing• Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic care (20 visit limit / year)• Habilitation	<ul style="list-style-type: none">• Hearing aids (Up to age 18)• Infertility treatment• Non-emergency care when traveling outside of the U.S. See the FEHB Plan Brochure for information	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 855-249-5005 (TTY: 711) or visit www.opm.gov/healthcare-insurance/healthcare. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: 1-855-249-5005 (TTY: 711).

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 1-855-249-5005 (TTY: 711).

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

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

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

—————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 <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other (blood work) <u>coinsurance</u>	0%

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	\$500
Copayments	\$10
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,270

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other (blood work) <u>coinsurance</u>	0%

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	\$0
Copayments	\$500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$700

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other (x-ray) <u>coinsurance</u>	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*)

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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>.

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 አርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚስተለው 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 Wùqù (Bassa) Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ Bàsòò-wùqù-po-nyò jũ ní, nìí, à wuqu kà kò dò po-poò bɛ̀n 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 bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, diiri gi. Kpọọ **1-800-632-9700** (TTY: **711**).

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

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

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' 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) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

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

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

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

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

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