

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.kp.org/plandocuments or call 1-855-249-5005 (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 1-855-249-5005 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 Individual / \$6,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,500 Self only enrollment; \$5,000 for any one member within a Family enrollment; \$9,000 for an entire 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 starting 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 1-855-249-5005 (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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	Not covered	None
	Specialist visit	25% coinsurance	Not covered	None
	Preventive care / screening / immunization	No charge, deductible does not apply.	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 25% coinsurance Lab tests: 25% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	\$10 (retail); \$20 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines. Formulary preventive drugs and contraceptives, in all tiers, are no charge, deductible does not apply.
	Preferred brand drugs	30% coinsurance up to \$100 (retail); 30% coinsurance up to \$200 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	50% coinsurance up to \$350 (retail); 50% coinsurance up to \$700 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Specialty drugs	50% coinsurance up to \$150 (retail) / prescription	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% 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	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	Not covered	Non-Plan Providers covered when temporarily outside the service area: 25% coinsurance .
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	Not covered	Annual Wellness Visit: No charge, deductible does not apply.
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	25% coinsurance	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	25% coinsurance	Not covered	None
	Childbirth/delivery facility services	25% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Limited to less than 8 hours / day and 28 hours / week, 100 visit limit / year.
	Rehabilitation services	Outpatient: 25% coinsurance Inpatient: 25% coinsurance	Not covered	Outpatient: 60 visit limit / therapy / year. Inpatient: Multi-disciplinary facility limited to 60-days / condition / year.
	Habilitation services	25% coinsurance	Not covered	60 visit limit / therapy / year.
	Skilled nursing care	25% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	25% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice services	25% 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 your child needs dental or eye care	Children's eye exam	25% coinsurance for refractive exam.	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care (30 visit limit / year)
- Hearing aids (Up to age 18: 1 aid / ear / 60 months)
- Infertility treatment
- Private-duty nursing (Inpatient)
- 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	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	1-303-894-7490 (instate, toll-free: 1-800-930-3745) or insurance@dora.state.co.us

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).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-249-5005 (TTY: 711).

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

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-249-5005 (TTY: 711) uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5005 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 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 deductible	\$6,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (blood work) coinsurance	25%

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	\$5,000
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$60**

The total Peg would pay is **\$5,060**

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (blood work) coinsurance	25%

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	\$3,000
Copayments	\$100
Coinsurance	\$200

What isn't covered

Limits or exclusions **\$0**

The total Joe would pay is **\$3,300**

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other (x-ray) coinsurance	25%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)

[Diagnostic test](#) (*x-ray*)

[Durable medical equipment](#) (*crutches*)

[Rehabilitation services](#) (*physical therapy*)

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

In this example, Mia would pay:

Cost Sharing

Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$0**

The total Mia would pay is **\$2,800**

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

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	SAKS Fifth Ave CO Silver HDHP
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health Maintenance Organization (HMO)
3. Areas of Colorado where plan is available.	<p>Plan is available only in the following counties:</p> <p>Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld</p> <p>KP Select Plan: El Paso and Teller</p>

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>AGGREGATE DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.</p>
5. Out-of-Pocket Maximum	<p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.</p>
6. What is included in the In-Network Out-of-Pocket Maximum?	<p>Deductibles, coinsurance and copayments.</p> <p>As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement.</p>
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, mammogram, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA)
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USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility.
10. Does the plan have a binding arbitration clause?		No

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

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

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

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

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, 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, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- 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 **1-800-632-9700 (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, ancestry, age, disability, sex,(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700 (TTY 711)**.

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**, (TTY **1-800-537-7697**). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at

<https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

አማርኛ (Amharic) ቴክኒክ: አማርኛ የሚገኘው ከሆነ ተገበር የሆነ ሂደት መረጃዎችን እና አገልግሎቶችን ይጠማል የቁንቃዎች እርምጃ አገልግሎቶች በፊደል ይገልጻል:: በ 1-800-632-9700 ዓይነት (TTY 711)::

العربية (Arabic) تنبية: إذا كنت تتحدث العربية، توفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم 1-800-632-9700 (TTY 711)::

Ɓāsɔ́ò Wùdqù (Bassa) Mbi sog: nia maa Ɓàsàà, njàl mbom a ka maa njàng ndol ni mbom mi tsoŋ ni soŋ, niŋ ma kénŋen yé, mbi èyem. Wó nàŋ 1-800-632-9700 (TTY 711)

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 1-800-632-9700 (TTY 711)。

فارسی (Farsi) توجیه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با 1-800-632-9700 (تلفن متنی) 711 تماش بگیرید.

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le 1-800-632-9700 (TTY 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-800-632-9700 an (TTY 711).

Igbo (Igbo) TINYE UCHE: Ọ bụru na ị na-asụ Igbo, Ọru enyemaka nke asusu gunyere udi enyemaka na ọru kwesịri ekwesi, n'efu, dí nye gi. Kpọọ 1-800-632-9700 (TTY 711).

日本語 (Japanese) 注意：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。1-800-632-9700 までお電話ください (TTY : 711)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. 1-800-632-9700 로 전화해 주세요(TTY 711).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-632-9700 (TTY 711).

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाईँ नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन 1-800-632-9700 (TTY: 711).

Afaan Oromoo (Oromo) XIYYEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. 1-800-632-9700 irratti bilbilaa (TTY 711)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру 1-800-632-9700 (TTY 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-800-632-9700 (TTY 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700 (TTY 711)**.

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn 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. Xin gọi **1-800-632-9700 (TTY 711)**.

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá n sọ èdè Yorùbá, àwọn ishé ìrànlówó èdè tó fi kún àwọn ohun èlò ìrànlówó tó yé àti àwọn ishé lálsí ìdíyelé wà fún ọ. Pe **1-800-632-9700 (TTY 711)**.