




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://kp.org/plandocuments> or call 1-800-278-3296 (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 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$2,000 Self only enrollment, \$3,300 for any one member within a Family enrollment, \$4,000 for an entire 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 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 ?	\$3,300 Self only enrollment, \$3,300 for any one member within a Family enrollment, \$6,200 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 1-800-278-3296 (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.

Important Questions	Answers	Why this Matters:
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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 / visit	Not Covered	None
	Specialist visit	\$30 / visit	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)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	\$50 / procedure	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 (Tier 1)	Retail: \$10 / prescription ; Mail order: \$20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Preferred brand drugs (Tier 2)	Retail: \$30 / prescription ; Mail order: \$60 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	Retail: \$30 / prescription ; Mail order: \$60 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	\$30 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	\$100 / visit	\$100 / visit	None
	Emergency medical transportation	\$100 / trip	\$100 / trip	None
	Urgent care	\$30 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: \$30 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: \$30 / individual visit. No Charge for other outpatient services; Substance Abuse: \$30 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: \$15 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	\$250 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge, deductible does not apply.	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services are included in the Facility services.
	Childbirth/delivery facility services	\$250 / admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: \$250 / admission; Outpatient: \$30 / visit	Not Covered	None
	Habilitation services	\$30 / visit	Not Covered	None
	Skilled nursing care	\$250 / admission	Not Covered	100 day limit / benefit period.
	Durable medical equipment	20% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$30 / visit for refractive exam, deductible does not apply.	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 .)		
Children's glasses Chiropractic care Cosmetic surgery Dental Care (Adult & Child)	Hearing aids 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.)		
Acupuncture (plan provider referred)	Bariatric surgery	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	1-800-278-3296 (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
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.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 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-278-3296 (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	\$3,300
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other (blood work) copayment	\$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:	
<i>Cost Sharing</i>	
Deductibles	\$3,300
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$3,350

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other (blood work) copayment	\$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:	
<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,600

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other (x-ray) copayment	\$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:	
<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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

Nondiscrimination Notice

In this document, we “us” or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at kp.org.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

No-cost aids and services to people with disabilities to help them communicate better with us, such as:

- ◆ Qualified sign language interpreters
- ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)

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 our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week.

Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week.

All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

By phone: Call our Member Services department. Phone numbers are listed above.

By mail: Download a form at kp.org or call Member Services and ask them to send you a form that you can send back.

In person: Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)

Online: Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below :

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

By phone: Call DHCS Office of Civil Rights at **916-440-7370** (TTY 711)

By mail: Fill out a complaint form or send a letter to:

Office of Civil Rights
Department of Health Care Services
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

California Department of Health Care Services Office of Civil Rights Complaint forms are available at:
http://www.dhcs.ca.gov/Pages/Language_Access.aspx

Online: Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

By phone: Call **1-800-368-1019** (TTY 711 or **1-800-537-7697**)

By mail: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: **<https://www.hhs.gov/bcr/office/file/index.html>**

Online: Visit the **Office of Civil Rights Complaint Portal** at: **<https://ocrportal.hhs.gov/bcr/screen/main.jsf>**

English: ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

All others: 1-800-464-4000 (TTY 711), 24 hours a day, 7 days a week

- Medicare، اې في القوڊ D-SNP وټه: **1-800-443-0815** (TTY 711)، 8 صلاحيابلې ۸ س م ء، 7 ي اما فيل اعوسا
- Medi-Cal: وټه **1-855-839-7613** (TTY 711)، 24 سه عا فينولامو، 7 ي اما فيل اعوسا
- لاريورخ آج اعيم: **1-800-464-4000** (TTY 711)، 24 سه عا فينولامو، 7 ي اما فيل اعوسا

Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY 711), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
 Medi-Cal՝ **1-855-839-7613** (TTY 711), օրը 24 ժամ, շաբաթը 7 օր
 Մյուս բոլորը՝ **1-800-464-4000** (TTY 711), օրը 24 ժամ, շաբաթը 7 օր



KAISER PERMANENTE®

Medicare , 包括 D-SNP : **1-800-443-0815 (TTY 711)**, 每周 7 天, 上午 8 点至晚上 8 点
Medi-Cal : **1-855-839-7613 (TTY 711)**, 每周 7 天, 每天 24 小时
所有其他保险计划 : **1-800-757-7585 (TTY 711)**, 每周 7 天, 每天 24 小时

Farsi: پیغام. مل اکسینم هر ه ید زاسم تدعلب زین لبه طرو رن گئی پ یاشام ودوج ددرا. هتی هینا ختامد تهم غشایه ار دتس اوخری گید، زا ج لیت من ام ج ربز ناش اهره. هین چم هتی هینا مبلط نش هم جهب مز نا خرن ددو لی درلقب ه یا ج ری زگی ار دتس اوخری گید، زا ج لم خط یلی، یفلل صتو، لی چ پابل ح فور دتشر. هین چم هتی هینا مل لاک و مگتس ده یک یکم ار زا مکار ام دتس اوخری گیدی. پ یا دتس اوخری گید، بل ختامد علیاض ایتس ام گیری. ختامد علیاض، در یی تلایطسری مبهت سات.

- Medicare، ل هاش D-SNP : **1-800-443-0815 (TTY 711)** 8 ص صر، در 7 روز هتس ام گیری
- Medi-Cal: **1-855-839-7613 (TTY 711)**، در 24 ست علش رفازو، 7 روز هتس ام گیری
- ه م مراهویوگ: **1-800-464-4000 (TTY 711)**، در 24 ست علش رفازو، 7 روز هتس ام گیری

Hindi:

Medicare, D-SNP : **1-800-443-0815 (TTY 711)**, 8 , 7
Medi-Cal: **1-855-839-7613 (TTY 711)**, 7
: **1-800-464-4000 (TTY 711)**, 7

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnuv so uas tseem ceeb.

Medicare, suav nrog D-SNP: **1-800-443-0815 (TTY 711)**, 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnuv hauv ib lub vij
Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij
Tag nrho lwm yam: **1-800-464-4000 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij

Japanese: ご注意. 言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業していません。

D-SNP を含む Medicare: **1-800-443-0815 (TTY 711)**、午前 8 時から午後 8 時まで、年中無休
Medi-Cal: **1-855-839-7613 (TTY 711)**、24 時間、年中無休
その他全て: **1-800-464-4000 (TTY 711)**、24 時間、年中無休

Khmer (Cambodian):

Medicare, D-SNP: **1-800-443-0815** (TTY **711**) " 8 8 7
 Medi-Cal: **1-855-839-7613** (TTY **711**) 24 " 7
1-800-464-4000 (TTY **711**) 24 " 7

Korean:

가 가
 Medicare(D-SNP), 7 8 ~ 8 **1-800-443-0815** (TTY **711**)
 Medi-Cal: **1-855-839-7613** (TTY **711**), 7 , 24
 : **1-800-464-4000** (TTY **711**), 7 , 24

Laotian:

Medicare, D-SNP: **1-800-443-0815** (TTY **711**), 8
 Medi-Cal: **1-855-839-7613** (TTY **711**), 24
1-800-464-4000 (TTY **711**), 24

Medicare, D-SNP: **1-800-443-0815** (TTY **711**), 8
 Medi-Cal: **1-855-839-7613** (TTY **711**), 24
1-800-464-4000 (TTY **711**), 24

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fievc da'nyeic diuc daan, fievc benx domh nzangc-pokc bun hluc, bungx waac-qiez bun uangx, a'fai aamx bievc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
 Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
 Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: GIHA. Tsée' naalkáah síd'á'gíí éí doo t'ée' íł'í' dah síd'á'gíí. Tł'ée' góó t'í'z'í'gíí éí tsée' naalkáah síd'á'gíí bik'áa' dah síd'á'gíí, t'á' ii bik'eh dah na'álkaígíí. T'á' ii éí t'ée' góó t'í'z'í'gíí bik'eh dah deidiyós, t'á' ii éí bi'ée' bik'eh dah na'álkaígíí bik'eh dah deidiyós. T'á' ii bik'eh dah na'álkaígíí bik'áa' dah na'álkaígíí t'áá' áłtso bik'eh dah deidiyós. Bi'ée' naalkáah síd'á'gíí bik'eh ha'a'aah. T'á' ii bik'eh dah na'álkaígíí bik'eh dah naazhja'í'gíí bik'eh dah na'álkaígíí.

Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. góó 8 p.m., 7 jǵ t'áálá'í damóo
Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 tǵ'ohch'oolí t'áálá'í jǵ, 7 jǵ t'áálá'í damóo
T'áá al'aa: **1-800-464-4000 (TTY 711)**, 24 tǵ'ohch'oolí t'áálá'í jǵ, 7 jǵ t'áálá'í damóo

Punjabi:

Medicare, D-SNP : **1-800-443-0815 (TTY 711)**, 8 8 , 7
Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 , 7
: **1-800-464-4000 (TTY 711)**, 24 , 7

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

Medicare, включая D-SNP: **1-800-443-0815 (TTY 711)**, без выходных с 8:00 до 20:00.
Medi-Cal: **1-855-839-7613 (TTY 711)**, круглосуточно без выходных.
Любые другие поставщики услуг: **1-800-464-4000 (TTY 711)**, круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

Medicare, incluyendo D-SNP: **1-800-443-0815 (TTY 711)**, de 8 a. m. a 8 p. m., los 7 días de la semana.
Medi-Cal: **1-855-839-7613 (TTY 711)**, las 24 horas del día, los 7 días de la semana.
Todos los otros: **1-800-788-0616 (TTY 711)**, las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

Medicare, kasama ang D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo
Ang lahat ng iba: **1-800-464-4000 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo

Thai: สงฆ์ บริ การให้ อดั นภาพพจน์ นโดยไม่ จมึ านอื่ บบริ กรรณ ี่ ามภาษามที่ ่อัด
ในั นภาพพจน์ หือในรู ปแบบนั นการัน กษณลั ฟล์ อดั วอ์ กษณนาถุใหญ่ นสามารถนอ์ กษณ
แะลอกการณ เสรณ มเต ื่อ ให้ กษณกรรณ อฝั ยบรี ่อขคณ อไ้ ี่ การสข านดฬั การใน
ว นหญ ตรากการค ่างๆ บรี ดั กษณภาพ พ็ บชลั ยบรี มชฬ

Medicare รวมถึ D-SNP: 1-800-443-0815 (TTY 711) 8.00 น. ถึ 20.00 น.หรื 5 นด่บ
 ำ Medi-Cal: 1-855-839-7613 (TTY 711) ตลอด 24 ช้โมง หรื 5 วั นด่บ
 อี ั หน้ ำ 1-งหน้ 800-464-4000 (TTY 711) ตลอด 24 ้ง หรื 5 วั นด่บ

മുഖം

Ukrainian: УВАГА! Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

Medicare, зокрема D-SNP: **1-800-443-0815** (TTY 711), з 8:00 до 20:00, без вихідних.

Medi-Cal: 1-855-839-7613 (TTY 711), цілодобово, без вихідних.

Усі інші надавачі послуг: **1-800-464-4000 (TTY 711)**, цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

Medicare, bao gồm cả D-SNP: **1-800-443-0815 (TTY 711)**, 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần.

Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần.

Mọi chương trình khác: **1-800-464-4000 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần.

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