



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 1-800-278-3296 (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 <https://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 ? | \$500 Individual / \$1,000 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 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. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 Individual / \$6,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , health care this plan doesn't cover, and services indicated in chart 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 providers 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 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 | \$20 / visit, deductible does not apply. | Not Covered | None |
| | Specialist visit | \$20 / visit, deductible does not apply. | Not Covered | Services related to infertility covered at 50% coinsurance / visit. |
| | 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 you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$10 / encounter, deductible does not apply. | Not Covered | None |
| | Imaging (CT/PET scans, MRI's) | \$50 / procedure, deductible does not apply. | 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 |
|--|--|---|---|--|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.kp.org/formulary.</p> | Generic drugs | <p>Plan pharmacy: \$10 / prescription for 1 to 30 days, deductible does not apply ; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply</p> | Not Covered | Does not apply to the out-of-pocket limit . In accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Preferred brand drugs | <p>Plan pharmacy: \$30 / prescription for 1 to 30 days, deductible does not apply ; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply</p> | Not Covered | Does not apply to the out-of-pocket limit . In accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| | Non-preferred brand drugs | Same as preferred brand drugs | Not Covered | Same as preferred brand drugs when approved through exception process. |
| | Specialty drugs | \$30 / prescription for 1 to 30 days, deductible does not apply. | Not Covered | Does not apply to the out-of-pocket limit . In accordance with formulary guidelines. Certain drugs may be covered at a different cost share. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance / procedure | Not Covered | None |
| | Physician/surgeon fees | 10% coinsurance / procedure | Not Covered | None |
| If you need immediate medical attention | Emergency room care | 10% coinsurance / visit | 10% coinsurance / visit | None |
| | Emergency medical transportation | \$150 / trip, deductible does not apply. | \$150 / trip, deductible does not apply. | None |
| | Urgent care | \$20 / visit, deductible does not apply. | \$20 / visit, deductible does not apply. | Non- Plan providers covered when outside the service area. |

| 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 a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance / admission | Not Covered | None |
| | Physician/surgeon fee | 10% coinsurance / admission | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Mental / Behavioral Health: \$20 / individual visit, deductible does not apply. 10% coinsurance / day for other outpatient services; Substance Abuse: \$20 / individual visit, deductible does not apply. 10% coinsurance / day up to \$5 maximum for other outpatient services, deductible does not apply. | Not Covered | Mental / Behavioral Health: \$10 / group visit; Substance Abuse: \$5 / group visit. |
| | Inpatient services | 10% coinsurance / 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 | 10% coinsurance / admission | Not Covered | None |
| | Childbirth/delivery facility services | 10% coinsurance / 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, deductible does not apply. | Not Covered | Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year. | |
| | Rehabilitation services | Inpatient: 10% coinsurance / admission; Outpatient: \$20 / visit, deductible does not apply. | Not Covered | None | |
| | Habilitation services | \$20 / visit, deductible does not apply. | Not Covered | None | |
| | Skilled nursing care | 10% coinsurance / admission, deductible does not apply. | Not Covered | Up to 100 days maximum / benefit period. | |
| | Durable medical equipment | 20% coinsurance / item, deductible does not apply. | Not Covered | Must be in accordance with formulary guidelines. Requires prior authorization. | |
| | Hospice service | No Charge, deductible does not apply. | Not Covered | Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less. | |
| | If your child needs dental or eye care | Children's eye exam | No Charge, deductible does not apply. | Not Covered | None |
| | | Children's glasses | Not Covered | Not Covered | None |
| | | Children's dental check-up | Not Covered | Not Covered | You may have other dental coverage not described here. |

Excluded Services & Other Covered Services:

| | | |
|--|--|--|
| <p>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</p> | | |
| <ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care unless medically necessary • Weight loss programs |

| | | |
|--|---|--|
| <p>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</p> | | |
| <ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery | <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • 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 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 agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or [http://www.HealthHelp.ca.gov](#).

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.healthhelp.ca.gov |

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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)

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)

NAVAJO (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 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](#) \$500
- [Specialist copayment](#) \$20
- [Hospital \(facility\) coinsurance](#) 10%
- [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*)

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

- [The plan's overall deductible](#) \$500
- [Specialist copayment](#) \$20
- [Hospital \(facility\) coinsurance](#) 10%
- [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*)

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

- [The plan's overall deductible](#) \$500
- [Specialist copayment](#) \$20
- [Hospital \(facility\) coinsurance](#) 10%
- [Other \(x-ray\) copayment](#) \$10

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Durable medical equipment (*crutches*)
Diagnostic test (*x-ray*)
Rehabilitation services (*physical therapy*)

| | |
|-----------------------------------|-----------------|
| Total Example Cost | \$12,800 |
| In this example, Peg would pay: | |
| Cost Sharing | |
| Deductibles | \$500 |
| Copays | \$200 |
| Coinsurance | \$900 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,660 |

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

| | |
|-----------------------------------|----------------|
| Total Example Cost | \$7,400 |
| In this example, Joe would pay: | |
| Cost Sharing | |
| Deductibles | \$0 |
| Copays | \$1,100 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$50 |
| The total Joe would pay is | \$1,350 |

| | |
|-----------------------------------|----------------|
| Total Example Cost | \$1,900 |
| In this example, Mia would pay: | |
| Cost Sharing | |
| Deductibles | \$500 |
| Copays | \$300 |
| Coinsurance | \$10 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$810 |

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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 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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, MediCal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), MediCal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles (Office for Civil Rights), en ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo postal o por teléfono a: U. S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, H-H Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente 禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計劃成員服務聯絡中心提供語言協助服務；每週七天 24 小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以便您使用本機構的設施與服務。此外，您還可請求以您的語言提供健康保險計劃資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用爭議解決方案，請參閱您的《承保範圍說明書》（*Evidence of Coverage*）或《保險證明書》（*Certificate of Insurance*），或者與計劃成員服務代表交談。對於 Medicare、MediCal、MRMIP、MediCal Access、FEHBP 或 CalPERS 計劃成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：

- 於設在本計劃服務設施的某個計劃成員服務處填寫一份《投訴或保險福利索償請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 將您的冤情申訴書郵寄至設在本計劃服務設施的某個計劃成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 免費致電本機構的計劃成員服務聯絡中心，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）
- 在本機構的網站上填寫一份冤情申訴書，網址是 **kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計劃成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給 Kaiser Permanente 的民權事務協調員（Civil Rights Coordinator）。您也可以與 Kaiser Permanente 的民權事務協調員直接聯絡；聯絡地址是 One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以採用電子方式透過民權辦公處（Office for Civil Rights）的投訴人口網站（Civil Rights Complaint Portal）向美國衛生與公共服務部民權辦公處（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是 ocrportal.hhs.gov/ocr/portal/lobby.jsf；或者按照如下聯絡資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線）。可從網站上下載投訴書，網址是 www.hhs.gov/ocr/office/file/index.html。

Language Assistance Services

English: We provide interpreter services at no cost to you, 24 hours a day, 7 days a week, during all hours of operation. You can have an interpreter help answer your questions about our health care coverage. You can also request materials translated in your language at no cost to you. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: نؤمن خدمات الترجمة الفورية مجانًا لك على مدار الساعة كافة أيام الأسبوع طوال ساعات العمل. بإمكانك طلب مساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التغطية الصحية التي تقدمها. بالإضافة إلى ذلك، يمكنك طلب ترجمة الوثائق الطبية للغتك مجانًا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات).
مستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم **(711)**.

Armenian: Մենք օրը 24 ժամ, շաբաթը 7 օր, սեր աշխատանքի բոլոր ժամերին ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ ենք տրամադրում: Թարգմանչի օգնությամբ Ղոթ կարող եք պատասխան տալ նաև ձեր հարցերին՝ սեր կողմից տրամադրվող առողջության ապահովագրության վերաբերյալ: Կարող եք նաև ձեր լեզվով թարգմանված գրավոր նյութեր խնդրել, որոնք ձեզ համար անվճար են: Պարզապես գանգախաղեք սեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է գանգախաղեն **711** համարով:

Farsi: ما خدمات مترجم شفاهی را در 24 ساعت شبانه روز و 7 روز هفته در طول همه ساعات کاری بدون اخذ هزینه در اختیار شما قرار می دهیم. شما می توانید برای کمک در پاسخگویی به سوالات خود در مورد پوشش مراقبت درمانی ما از یک مترجم شفاهی بهره مند شوید. همچنین می توانید درخواست کنید که همه جزوات بدون اخذ هزینه به زبان شما ترجمه شوند. کافیت در 24 ساعت شبانه روز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: हम संचालन के सभी घंटों के दौरान आपको बिना किसी लागत के दुआषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन प्रदान करते हैं। आप हमारी स्वास्थ्य देखभाल कवरज के बारे में आपके प्रश्नों के जवाब के लिए एक दुआषिये की सहायता ले सकते हैं। आप बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए अनुरोध भी कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियाँ वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Peb muaj neeg txhais lus pub dawb rau koj, 24 teev ib hhub twg, 7 hhub ib lim tiam twg, thawm cov sij hawm qhib ua lag luam. Koj muaj tau ib tug neeg txhais lus los pab teb koj cov lus nug txog peb cov kev pab them nqi kho mob. Koj thov tau kom muab cov ntaub ntawv txhais uas koj hom lus pub dawb rau koj. Tsuas hu rau **1-800-464-4000**, 24 teev ib hhub twg, 7 hhub ib lim tiam twg (cov hhub caiv kaw). Cov neeg siv TTY hu 711.

Japanese: 当院では、全診療時間を通じて、通訳サービスを無料で、年中無休、終日ご利用いただけます。当院の医療内容についてのご質問および回答には、通訳がお手伝いいたします。また、日本語に翻訳された資料を無料で請求できます。お気軽に **1-800-464-4000** までお電話ください (祭日を除き年中無休)。TTY ユーザーは 711 にお電話ください。

Khmer: យើងផ្តល់សេវាបកប្រែភាសាសម្រាប់អ្នកប្រើប្រាស់ ជោយឥតគិតថ្លៃដល់អ្នកទូទៅ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ ក្នុងអំឡុងពេលធ្វើការទាងអស់ៗ អ្នកអាចមានអ្នកបកប្រែ ជំនាញជួយផ្តល់សេវាបកប្រែសម្រាប់ អំពីការប្រើប្រាស់ឱ្យបានល្អ។ អ្នកក៏អាចស្នើសុំសំណុំ ព័ត៌មាន ជោយឥតគិតថ្លៃដល់អ្នកដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បើទិវាបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711** ។

Korean: 업무 시간 동안에는 요일 및 시간에 관계없이 통역 서비스를 무료로 이용하실 수 있습니다. 통역의 도움을 받아 건강 보험 혜택에 관하여 질문하고 답변을 들으실 수 있습니다. 또한, 귀하가 사용하는 언어로 번역된 자료를 요청해 무료로 제공받을 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화해 문의하십시오(공휴일 휴무). TTY 사용자 번호 **711**.

Navajo: Nihí ata' halne' é áká' adoolwołgíí nihei hóló t'áá jíík' é, t'áá naadiin díí' ahé'íikkeedgo, tsoosts'id yiskááji', ndá'anishgo ooklìh biyi' góné. Ata' halne' é níká' adoolwol na 'ídikid nee hólóógó díí ats' ís baa áháyáá bik' éstí' ígíí biná' ídikidgo. Á ádóó áldó' naaltsóos lá t'áá ní nizaad k' ehji álnéehgo t'áá jíík' é ádoolníí. Nihí'í' hodíílinih kojí' **1-800-464-4000** jííigo dóó t'ée' nidi, tsoosts'id yiskááji' dimoo na' adleehjí' (Holidaysgo éí da' deelkaal) doo da' diits' a' ígíí chodayoof' íngíí kojí' hodíílinih **711**

Punjabi: ਅਸੀਂ ਬਰਵਾਰੀ ਦੇ ਸਾਰੇ ਖੰਟਿਆਂ ਦੇ ਦੌਰਾਨ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਝਾਸੀਆ ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਰਵਾਉਣ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੁਝਾਸੀਏ ਦੀ ਮਦਦ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੈਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦੇ ਹਨ) ਡੈਨ ਕਰੋ। TTY'ਚ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਡੈਨ ਕਰਨ।

Russian: Мы всегда в часы работы обеспечиваем Вас услугами устного переводчика, 24 часа в сутки, 7 дней в неделю. Чтобы получить ответы на свои вопросы о нашем страховом покрытии услуг здравоохранения, Вы можете воспользоваться помощью устного переводчика. Вы также можете запросить бесплатный перевод материалов на Ваш язык. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Ofrecemos servicios de traducción al español sin costo alguno para usted durante todo el horario de atención, 24 horas al día, siete días a la semana. Puede contar con la ayuda de un intérprete para responder las preguntas que tenga sobre nuestra cobertura de atención médica. Además, puede solicitar que los materiales se traduzcan a su idioma sin costo alguno. Solo llame al **1-800-788-0616**, 24 horas al día, siete días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na mga serbisyo ng tagasalin ng wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo, sa lahat oras ng trabaho. Makakatulong ang tagasalin ng wika sa pagsagot sa mga tanong mo tungkol sa iyong coverage sa pangangalagang pangkalusugan. Maaari kang humingi ng mga babasahin na isinalin sa iyong wika nang wala kang babayaran. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 ชั่วโมง ทุกวันตลอดชั่วโมง ทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวข้องกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้การแปลเอกสารเป็นภาษาที่คุณใช้ก็ได้โดยไม่มีค่าบริการเพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ **711**

Chinese: 我們每週 7 天，每天 24 小時在所有營業時間內免費為您提供口譯服務。您可以請口譯員協助回答有關我們健康保險的問題。您也可以以免費索取翻譯成您所用語言的資料。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần, trong tất cả các giờ làm việc. Quý vị có thể được thông dịch viên giúp trả lời thắc mắc về quyền lợi bảo hiểm sức khỏe của chúng tôi. Quý vị cũng có thể yêu cầu được cấp miễn phí tài liệu phiên dịch ra ngôn ngữ của quý vị. Chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

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