



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or by calling 1-800-278-3296.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>\$3,000</b> Individual/ <b>\$6,000</b> Family (See chart starting on page 2 for when deductible is waived.)	You must pay all the costs up to the <b>deductible</b> amount before this <b>plan</b> begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1). The Common Medical Events chart below shows how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	<b>Yes. \$6,000</b> Individual/ <b>\$12,000</b> Family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	<b>Yes.</b> For a list of <b>plan providers</b> , see <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	<b>Yes</b> , but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
Are there services this plan doesn't cover?	<b>Yes.</b>	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-278-3296 or 711 (TTY), or visit us at [www.kp.org](http://www.kp.org).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the

Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-800-278-3296 or 711 (TTY) to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance per visit	Not Covered	After deductible.
	Specialist visit	30% coinsurance per visit	Not Covered	After deductible. Services related to infertility covered at 50% coinsurance per visit.
	Other practitioner office visit	30% coinsurance per visit for acupuncture services.	Not Covered	After deductible. Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Deductible waived. Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: 30% coinsurance per encounter; Lab tests: 30% coinsurance per encounter	Not Covered	After deductible.
	Imaging (CT/PET scans, MRI's)	30% coinsurance per procedure	Not Covered	After deductible.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> .	Generic drugs	30% coinsurance per prescription up to \$50 maximum for 1 to 100 days	Not Covered	Overall deductible waived. In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	30% coinsurance per prescription up to \$100 maximum for 1 to 100 days	Not Covered	Overall deductible waived. 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% coinsurance per prescription up to \$150 maximum for 1 to 30 days	Not Covered	Overall deductible waived. In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance per procedure	Not Covered	After deductible.
	Physician/surgeon fees	30% coinsurance per procedure	Not Covered	After deductible.
<b>If you need immediate medical attention</b>	Emergency room services	30% coinsurance per visit	30% coinsurance per visit	After deductible.
	Emergency medical transportation	30% coinsurance per trip	30% coinsurance per trip	After deductible.
	Urgent care	30% coinsurance per visit	30% coinsurance per visit	After deductible. Non-Plan providers covered when outside the service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance per admission	Not Covered	After deductible.
	Physician/surgeon fee	30% coinsurance per admission	Not Covered	After deductible.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	30% coinsurance per individual visit; 30% coinsurance per group visit. 30% coinsurance per day for other outpatient services	Not Covered	Individual and group visits: After deductible; Other outpatient services: After deductible.
	Mental/Behavioral health inpatient services	30% coinsurance per admission	Not Covered	After deductible.
	Substance use disorder outpatient services	30% coinsurance per individual visit; 30% coinsurance per group visit. 30% coinsurance per day for other outpatient services	Not Covered	Individual and group visits: After deductible; Other outpatient services: After deductible.
	Substance use disorder inpatient services	30% coinsurance per admission	Not Covered	After deductible.
<b>If you are pregnant</b>	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal care: Deductible waived. Cost sharing is for routine preventive care only; Postnatal care: Deductible waived. Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	30% coinsurance per admission	Not Covered	After deductible.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	No Charge	Not Covered	Deductible waived. Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per year.
	Rehabilitation services	Inpatient: 30% coinsurance per admission; Outpatient: 30% coinsurance per visit	Not Covered	After deductible.
	Habilitation services	30% coinsurance per visit	Not Covered	After deductible.
	Skilled nursing care	30% coinsurance per admission	Not Covered	After deductible. Up to 100 days maximum per benefit period.
	Durable medical equipment	30% coinsurance per item	Not Covered	Deductible waived. Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Deductible waived. Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.
<b>If your child needs dental or eye care</b>	Eye exam	No Charge	Not Covered	Deductible waived.
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

### Excluded Services & Other Covered Services:

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care unless medically necessary</li> <li>• Weight loss programs</li> </ul>

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture (plan provider referred)</li><li>• Bariatric surgery</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li></ul> |
|--|---|--|

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-278-3296. You may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa); or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Kaiser Permanente at 1-800-278-3296 or online at [www.kp.org/memberservices](http://www.kp.org/memberservices).

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), and the California Department of Insurance at 1-800-927-HELP (4357) or [www.insurance.ca.gov](http://www.insurance.ca.gov).

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or [www.insurance.ca.gov](http://www.insurance.ca.gov).

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	<a href="http://www.healthhelp.ca.gov">www.healthhelp.ca.gov</a>
Sacramento, CA 95814	<a href="mailto:helpline@dmhc.ca.gov">helpline@dmhc.ca.gov</a>

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 711

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

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

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

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,040
- Patient pays \$4,500

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient Pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$1,300
Limits or exclusions	\$200
<b>Total</b>	<b>\$4,500</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,120
- Patient pays \$2,280

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient Pays:

Deductibles	\$1,000
Copays	\$0
Coinsurance	\$1,200
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,280</b>



## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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BOARD OF PENSIONS

PID:35335 CNTR:1 EU:N/A Plan ID:7823 SBC ID:269612

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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](http://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](http://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](http://www.hhs.gov/ocr/office/file/index.html).

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# 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 مجاناً لك على مدار الساعة كافة أيام الأسبوع طوال ساعات العمل. بإمكانك طلب مساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التغطية الصحية التي نقدمها. بالإضافة إلى ذلك، يمكنك طلب ترجمة الوثائق الطبية للعنك مجاناً. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم **(711)**.

**Armenian:** Մենք օրը 24 ժամ, շաբաթը 7 օր, մեր աշխատանքի բոլոր ժամերին Ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ ենք տրամադրում: Թարգմանչի օգնությամբ Դուք կարող եք պատասխան ստանալ Ձեր հարցերին՝ մեր կողմից տրամադրվող առողջության ապահովագրության վերաբերյալ: Կարող եք նաև Ձեր լեզվով թարգմանված գրավոր նյութեր խնդրել, որոնք Ձեզ համար անվճար են: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711** համարով:

**Farsi:** ما خدمات مترجم شفاهی را در 24 ساعت شبانروز 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. کفایت در 24 ساعت شبانروز 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 दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन प्रदान करते हैं। आप हमारी स्वास्थ्य देखभाल कवरेज के बारे में आपके प्रश्नों के जवाब के लिए एक दुभाषिये 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 (छुट्टियों 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 hnuv twg, 7 hnuv 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 hnuv twg, 7 hnuv ib lim tiam twg (cov hnuv 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:** យើងផ្តល់សេវានៃអ្នកបកប្រែ ដោយឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ ក្នុងអំឡុងម៉ោងធ្វើការទាំងអស់។ អ្នកអាចមានអ្នកបកប្រែ ដើម្បីជួយ ឆ្លើយសំណួររបស់អ្នក អំពីការរ៉ាប់រងថែទាំសុខភាព រូបសម្បែង។ អ្នកក៏អាចស្នើសុំសៀវភៅ ដែលបានបកប្រែជាភាសាខ្មែរ ដោយឥតគិតថ្លៃដល់អ្នកដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមល្វែខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បំបែកថ្ងៃបុណ្យ)។ 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 질문 하고 답변을 들으실 수 있습니다. 또한, 귀하가 사용하는 언어로 번역된 자료를 요청해 무료로 제공받으실 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'adoolwohígíí nihei hóló t'áá jíík'é, t'áá naadiin díí' ahéé'iilkeedgo, tsosts'id yiskáají, ndá'anishgo oolkił biyi' góné. Ata' halne'é nika'adoolwoł na'idikid nee hólóógo díí ats'íis baa áháyáa bik'estí'ígíí biná'idíikidgo. Áádóó áldó' naaltsoos lá t'áá ní nizaad k'ehji álnéehgo t'áá jíík'é ádoolníí. Nihíh'i' hodíílnih koji' **1-800-464-4000** jíigo dóó t'ée' nidi, tsosts'id yiskáají' dimoo na'adleejji' (Holidaysgo éi da'deelkaal) doo da'diits'a'ígíí chodayool'ínígíí koji' hodíílnih **711**

**Punjabi:** ਅਸੀਂ ਕਾਰਵਾਈ ਦੇ ਸਾਰੇ ਘੰਟਿਆਂ ਦੇ ਦੌਰਾਨ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਬਾਸੀਆ ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਵਰੇਜ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੁਬਾਸੀਏ ਦੀ ਮਦਦ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTYਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ 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 ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้ โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข **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**.