

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2018-12/31/2018



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 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?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	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?	\$3,000 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	Not Covered	None
	<u>Specialist</u> visit <u>Preventive care/ screening/ immunization</u>	\$35 / visit No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRI's)	No Charge \$100 / procedure	Not Covered	None
If you need drugs to treat your illness or condition	Generic drugs	Retail: \$10 / prescription; Mail order: \$20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives.
More information about <u>prescription drug coverage is available at www.kp.org/formulary.</u>	Preferred brand drugs	Retail: \$25 / prescription; Mail order: \$50 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <u>formulary</u> guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	<u>Specialty drugs</u>	\$25 / prescription	Not Covered	Up to a 30-day supply retail. Subject to <u>formulary</u> 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)	\$100 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	None
If you have a hospital stay	<u>Urgent care</u>	\$20 / visit	\$20 / visit	<u>Non-Plan providers</u> covered when temporarily outside the service area.
	Facility fee (e.g., hospital room)	\$250 / admission	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fee	No Charge	Not Covered	None
	Outpatient services	Mental / Behavioral Health: \$20 / individual visit. No Charge for other outpatient services; Substance Abuse: \$20 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: \$10 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient 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 are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$250 / admission	Not Covered	
	Home health care	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / year.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Inpatient: \$250 / admission; Outpatient: \$20 / visit	Not Covered	None
	<u>Habilitation services</u>	\$20 / visit	Not Covered	None
	<u>Skilled nursing care</u>	No Charge	Not Covered	Up to 100 days maximum / benefit period.
	<u>Durable medical equipment</u>	No Charge	Not Covered	Subject to <u>formulary</u> guidelines. Requires prior authorization.
	<u>Hospice service</u>	No Charge	Not Covered	None
	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none">• Acupuncture (plan provider referred)• Bariatric surgery	<ul style="list-style-type: none">• Chiropractic care (30 visit limit / year)• Infertility treatment

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.ccilio.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): Dinek'ehgo shika at'ohwol ninisingo, kwiiijo 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
<ul style="list-style-type: none"> ■ The plan's overall deductible ■ Specialist copayment ■ Hospital (facility) copayment ■ Other (blood work) copayment 	\$0 \$35 \$250 \$0	<ul style="list-style-type: none"> ■ The plan's overall deductible ■ Specialist copayment ■ Hospital (facility) copayment ■ Other (blood work) copayment 	\$0 \$35 \$250 \$0

This EXAMPLE event includes services like:
 Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (ultrasounds and blood work)
 Specialist visit (anesthesia)

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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copays	\$300	Copays	\$1,000	Copays	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$50	Limits or exclusions	\$0
The total Peg would pay is	\$360	The total Joe would pay is	\$1,050	The total Mia would pay is	\$300

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

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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

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 ocportal.hhs.gov/ocn/portal/lobby_isf, o por correo postal o por teléfono a: 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 (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畫資料之譯本，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妥一份《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妥一份冤情申訴書，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）的投訴入口網站（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/lobbyist/；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**.

Hmong: Peb muaj neeg txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub 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 thoy tau kom muab cov ntaub ntawv txhais lus kom lus pub dawb rau koj. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu 711.

Arabic: نؤمن بخدمات الترجمة الفورية مبنية على مدار الساعة كافية أيام الأسبوع طوال ساعات العمل. بكلناك للبمساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التخلصية الصحيحة التي يجري في كل يوم من أيام الأسبوع. **you just call us at ٠٣٥٤٣٤٦٠٠٠, 24 hours a week (closed holidays). TTY users call ٧١١.**

على الرقم 1-800-464-4000 على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات).
لعمليات: بـ ٢٠٢١، يبحث صب ترجحه المؤسق كافية أيام سوئى اتصالها.

Armenian: Մենք օր 24 ժամ, 2աբրի 7 օր, մեր աշխատանքի բոլոր հայերին շեղ համար անձնայր բանավոր թարգմանի կատարություններ ենք տրամադրում: Թարգմանչի օջնութեամբ Դուք կարող եք պատասխան տանալ Ձեր հարցերին՝ մեր կողմից սրբաւորության պահանջանառության վերաբերյալ: Կար եք լեզվով թարգմանված գլուխը նյութեր խնդրել դուքն Ձեզ՝ կամ նաև Ձեր լեզվով թարգմանված զանգվածի մեջ՝ **1-800-464-4000** համար անձնայր պահանջանառու՝ օրը 24 ժամ՝ 2աբրի 7 օր (առն օրերին փակ): ՏՏՎ-ից օգտվողներու պետք է զանազանութենք **711** համարով:

Farsi: ما خدمات مترجم شفاهی را در 24 ساعت شبانه‌روز و 7 روز هفته در طول هده ساعت کاری بخوب اخذ هزینه در اختیار شما قرار می‌دهیم. شما تواند برای کمک در پاسخگویی به سوالات خود در خواست کنید که همه جزویات بخوب اخذ هزینه به زبان شما ترجمه شوند. کافیست در 24 ساعت شبانه‌روز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره ۰۴۶۴-۴۰۰۰ تماس بگیرید که در آن ۷۱۱ شماره تلفنی بگیرید.

Hindi: हम संचालन के सभी घंटों के दौरान आपको बिना किसी लागत के दुआधिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन प्रदान करते हैं। आ हमारी स्वास्थ्य देखभाल कवरेज के बारे में आपके प्रश्नों के जवाब के लिए दुआधिये की सहायता ले सकते हैं। आप बिना किसी लागत के समस्विधों के अपनी भाषा में अनिवार्य कवराने के लिए अनुशोध भी कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छहियों वाले दिन बंद रहता है) काल करें। TTY उपयोगकर्ता 711 पर कानून करें।

Navajo: Nihí atá' halne'é áká'adoolwoligíí níhei hólq' t'áá jiik'é, t'áá naadiin díí ahéé' ilkeedgo, tsots' id yiskáají', ndá' anishgo oolkil biyí' goné. Atá' halne'é niká' adoolwoł na ídikid nee hólqógo díí ats'íís baa áláhayáa bik' éstí' ígíí biná' idílkidgo. Áádóó alldó' naaltsosos lá t'áá ni nizaad k'ehji álnéehgo t'áá jiik'é ádooon níit. Nihích'i' hodíílhíh koji' **1-800-464-4000** júgo dóó t'ee' nidi, tsots' id yiskáají' dimoo na'adleehjíí' (Holidaysgo éí da' deelkaal) doo da'díits' a'igíí chodayool' hiigíí kojí' hodíílhíh **711**.

Punjabi: ਅਸੀਂ ਕਾਰਵਾਈ ਦੇ ਸਾਰੇ ਪੰਥਿਆਂ ਦੇ ਦੇਚਾਨ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸੀਆ ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਰਵੇਂਦਾ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੂਜਾ ਸੀਵੇਂ ਦੀ ਮਦਦ ਹੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਕਿਨ੍ਤੂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਅਧਿਕ ਭਾਸਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੋਲਨੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ ਸਾਂਝੇ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫੇਨ ਕਰਨੀ। TTY ਦੇ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਵੇਣ 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 помочью 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 ТТУ могут звонить по номеру **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. Maari kang humingi ng mga babasa hin 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 maaring tumawag sa **711**.

Thai: เรามีบริการลามพรีสเซอร์บิลิตี้ตลอด 24 ชั่วโมง ทั้งนันดรอตท์ โนมั่ง ท่าการของราชบุรีและสุพรรณบุรีให้ล่วงช่วงเวลาตามห้องคุกที่เกี่ยวกับความดุณดร่องการดูแลและรักษาพยาบาลคุณภาพสูงในฝีมือทางการแพทย์ที่มาตรฐานและเชื่อถือได้ ภาษาไทยและภาษาอังกฤษสามารถใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรศัพท์ที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (โปรดให้บริการในวันหยุดราชการ) ผู้ช่วย TTY โปรดโทรที่ **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**.

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**.

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