



Southern California Drug Benefit Fund: Kaiser Gold

Coverage for: Individual/Family | Plan Type: DHMO



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/](http://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 <a href="#">deductible</a> ?                                | \$300 Individual / \$600 Family                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                      |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on page 2.                                                                                                                                                                                                                                                                                                                                                                                                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>Medical <a href="#">Out-of-Pocket Limit</a>:</b> \$2,000 Individual / \$4,000 Family<br><b><a href="#">Prescription Drug Out-of-Pocket Limit</a> (in-network):</b> Calendar year 2025: \$7,450 Individual / \$14,900 Family; Effective 1/1/26 for the 2026 calendar year: \$7,200 Individual / \$14,400 Family                                                                                                                                                                                              | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                       |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <b>Medical <a href="#">Out-of-Pocket Limit</a>:</b> <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.<br><b><a href="#">Prescription Drug Out-of-Pocket Limit</a> (applicable to <a href="#">prescription drugs</a> from <a href="#">network pharmacies</a>):</b> <a href="#">premiums</a> , <a href="#">deductibles</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Important Questions                                                          | Answers                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes, but you may self-refer to certain <a href="#">specialists</a> .                                                                    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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<br>(You will pay the least)                           | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                | Primary care visit to treat an injury or illness           | \$20 / visit, <a href="#">deductible</a> does not apply.                              | Not Covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                           | \$20 / visit, <a href="#">deductible</a> does not apply.                              | Not Covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | <a href="#">Preventive care/ screening/ immunization</a>   | No Charge, <a href="#">deductible</a> does not apply.                                 | Not Covered                                                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                       |
| If you have a test                                                                                                                                                                                                    | <a href="#">Diagnostic test</a> (x-ray, blood work)        | \$10 / encounter                                                                      | Not Covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRI's)                              | 20% <a href="#">coinsurance</a> up to \$50 / procedure                                | Not Covered                                                    | None                                                                                                                                                                                                                                                                                                                                                                              |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1800-788-7871. | Generic drugs                                              | \$12 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply. | Not Covered                                                    | <ul style="list-style-type: none"> <li>You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage.</li> <li>Your <a href="#">cost sharing</a> applies to the <a href="#">prescription drug out-of-pocket limit</a>, not to the medical <a href="#">out-of-pocket limit</a>.</li> </ul> |
|                                                                                                                                                                                                                       | <a href="#">Formulary</a> brand drugs (Preferred)          | \$30 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply. | Not Covered                                                    |                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                       | Non- <a href="#">Formulary</a> brand drugs (Non-Preferred) | \$50 <a href="#">copay</a> / prescription, <a href="#">deductible</a> does not apply. | Not Covered                                                    |                                                                                                                                                                                                                                                                                                                                                                                   |

| 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------|------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                                                |                                                                              |                                                             | <ul style="list-style-type: none"> <li>Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications).</li> <li>If you purchase a brand drug when a generic drug is available, you pay the brand drug <a href="#">copayment</a> plus the difference in cost between the brand drug and the generic drug, unless your <a href="#">provider</a> indicates “dispense as written.”</li> <li>Mail order available only outside California.</li> <li>See the website listed or call 1-800-788-7871 for information on drugs covered by your <a href="#">plan</a>. Not all drugs are covered.</li> </ul>                                                                                                                  |
|                      | <a href="#">Preventive care drugs</a>          | No charge, <a href="#">deductible</a> does not apply.                        | Not Covered                                                 | You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. You must have a prescription or no coverage. Coverage is for generic drugs only (or brand name if a generic drug is unavailable or medically inappropriate). <a href="#">Preventive care</a> drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer <a href="#">screening</a> prep products, tobacco cessation medications, statin preventive medication, breast cancer preventive medication (e.g., Tamoxifen), FDA-approved female contraceptives, and pre-exposure prophylaxis (PrEP) for persons at increased risk of HIV acquisition. Age and frequency limits apply. |
|                      | Injectable ( <a href="#">Specialty drugs</a> ) | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply. | Not Covered                                                 | <a href="#">Preauthorization</a> from OptumRx is required or no coverage. Call OptumRx at 800-788-7871.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay Plan Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                   | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                     |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | Not Covered                                                    | None                                                                                                                                                                      |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | Not Covered                                                    | None                                                                                                                                                                      |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | 20% <a href="#">coinsurance</a>                                | None                                                                                                                                                                      |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$150 / trip                                                                                                                                                                                                                                                                                                                                                                  | \$150 / trip                                                   | None                                                                                                                                                                      |
|                                                                           | <a href="#">Urgent care</a>                      | \$20 / visit, <a href="#">deductible</a> does not apply.                                                                                                                                                                                                                                                                                                                      | Not Covered                                                    | <a href="#">Non-Plan providers</a> covered when temporarily outside the service area: \$20 / visit, <a href="#">deductible</a> does not apply.                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | Not Covered                                                    | None                                                                                                                                                                      |
|                                                                           | Physician/surgeon fee                            | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | Not Covered                                                    | None                                                                                                                                                                      |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Mental / Behavioral Health: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> for other outpatient services; Substance Abuse: \$20 / individual visit, <a href="#">deductible</a> does not apply. 20% <a href="#">coinsurance</a> up to \$5 / day for other outpatient services, <a href="#">deductible</a> does not apply. | Not Covered                                                    | Mental / Behavioral Health: \$10 / group visit, <a href="#">deductible</a> does not apply; Substance Abuse: \$5 / group visit, <a href="#">deductible</a> does not apply. |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                               | Not Covered                                                    | None                                                                                                                                                                      |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay Plan Provider<br>(You will pay the least)                                                                                                       | What You Will Pay Non-Plan Provider<br>(You will pay the most)                                                                             | Limitations, Exceptions & Other Important Information                                                                                                                                                                                              |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you are pregnant                                            | Office visits                             | No Charge, <a href="#">deductible</a> does not apply.                                                                                                             | Not covered                                                                                                                                | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).            |
|                                                                | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                                                                                                                   | Not Covered                                                                                                                                | None                                                                                                                                                                                                                                               |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                                                                                                                   | Not Covered                                                                                                                                | None                                                                                                                                                                                                                                               |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No Charge, <a href="#">deductible</a> does not apply.                                                                                                             | Not Covered                                                                                                                                | 2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.                                                                                                                                                                                 |
|                                                                | <a href="#">Rehabilitation services</a>   | Inpatient: 20% <a href="#">coinsurance</a> ; Outpatient: \$20 / visit                                                                                             | Not Covered                                                                                                                                | None                                                                                                                                                                                                                                               |
|                                                                | <a href="#">Habilitation services</a>     | \$20 / visit                                                                                                                                                      | Not Covered                                                                                                                                | None                                                                                                                                                                                                                                               |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                                                                                                                   | Not Covered                                                                                                                                | 100 day limit / benefit period.                                                                                                                                                                                                                    |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.                                                                                      | Not Covered                                                                                                                                | Requires prior authorization.                                                                                                                                                                                                                      |
|                                                                | <a href="#">Hospice service</a>           | No Charge, <a href="#">deductible</a> does not apply.                                                                                                             | Not Covered                                                                                                                                | None                                                                                                                                                                                                                                               |
| If your child needs dental or eye care                         | Children's eye exam                       | <b>Kaiser:</b> No Charge, <a href="#">deductible</a> does not apply.<br><b>Trust Fund:</b> No charge, <a href="#">deductible</a> does not apply.                  | <b>Kaiser:</b> Not Covered<br><b>Trust Fund:</b> No charge, <a href="#">deductible</a> does not apply.                                     | <b>Trust Fund:</b> Maximum benefit of \$135 per exam.                                                                                                                                                                                              |
|                                                                | Children's glasses                        | <b>Kaiser:</b> Not Covered<br><b>Trust Fund:</b> You pay all charges over the Fund's allowance. <a href="#">Deductible</a> does not apply.                        | <b>Kaiser:</b> Not Covered<br><b>Trust Fund:</b> You pay all charges over the Fund's allowance. <a href="#">Deductible</a> does not apply. | <b>Trust Fund:</b> <a href="#">Allowed amount</a> of \$135 per year is reduced by the cost of eye exam(s) paid by the Fund. Pediatric vision benefits are for children up to 19 years. Unused vision benefits from 2025 roll over for use in 2026. |
|                                                                | Children's dental check-up                | <b>Kaiser:</b> Not Covered<br><b>Trust Fund:</b> You may elect dental coverage from the Indemnity Dental <a href="#">Plan</a> or the United Concordia Dental HMO. |                                                                                                                                            | Your dental coverage is not subject to health care reform.                                                                                                                                                                                         |

## 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](#).)

- |                     |                                                      |                                                                                      |
|---------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|
| ● Chiropractic care | ● Non-emergency care when traveling outside the U.S. | ● Routine foot care (Fund provides limited benefit of up to \$120 per calendar year) |
| ● Cosmetic surgery  | ● Private-duty nursing                               | ● Weight loss programs                                                               |
| ● Long-term care    |                                                      |                                                                                      |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                                                                       |                                                                                                        |                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| ● Acupuncture ( <a href="#">plan provider</a> referred)                                                               | ● Hearing aids (maximum benefit of \$750 for each ear in a 12-month period, payable through the Fund.) | ● Routine eye care (Adult) (Coverage for glasses and contacts is limited to Fund-provided benefit of \$135/year for exam, frames, and lenses) |
| ● Bariatric surgery                                                                                                   | ● Infertility treatment                                                                                |                                                                                                                                               |
| ● Dental care (Adult) (available under separate Indemnity Dental <a href="#">Plan</a> or United Concordia Dental HMO) |                                                                                                        |                                                                                                                                               |

**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](http://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 <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>     |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| California Department of Insurance                                                           | 1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                   |
| California Department of Managed Healthcare                                                  | 1-888-466-2219 or <a href="http://www.dmhca.gov">www.dmhca.gov</a>                                        |

### 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 Deitsch, 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$300           |
| <a href="#">Copayments</a>             | \$50            |
| <a href="#">Coinsurance</a>            | \$1,660         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$20            |
| <b>The total Peg would pay is**</b>    | <b>\$2,030</b>  |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$120          |
| <a href="#">Copayments</a>             | \$960          |
| <a href="#">Coinsurance</a>            | \$100          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$1,180</b> |

### Mia's Simple Fracture

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%   |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$300          |
| <a href="#">Copayments</a>             | \$340          |
| <a href="#">Coinsurance</a>            | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$840</b>   |

\*\*Note: The Patient Pays amount is capped at the [plan's out-of-pocket limit](#). Total amounts may not add up due to rounding.

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

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## 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](https://www.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](https://www.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](http://kp.org/facilities) for addresses)
- **Online:** Use the online form on our website at [kp.org](http://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](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)

- **Online:** Send an email to [CivilRights@dhcs.ca.gov](mailto: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 for 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 Right Complaint forms are available at:  
<https://www.hhs.gov/ocr/office/file/index.html>

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

## Notice of Language Assistance

**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.

- 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

**Arabic:** تنبيه، المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضاً طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. ال تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815 (TTY 711)**، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع

**Armenian:** ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- 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

**Chinese:** 请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的文本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- 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:** توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare, شامل D-SNP : با شماره **1-800-443-0815 (TTY 711)** از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613 (TTY 711)**، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000 (TTY 711)**، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

**Hindi:** ध्यान दें। भाषा सहायता आपके लिए बिना ककसी शुल्क के उपलब्ध है। आप दुभाषया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन **िैंग्वेि** के दुभाषये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, **िैंसे** कक ब्रैि, ऑडियो, या **िडे** प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुषधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा षवभाग को कॉि करें। सदस्य सेवा षवभाग मुख्य छुट्टियों वािें टदन िंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815 (TTY 711)**, सुिह 8 िििे से रात 8 िििे तक, सप्ताह के 7 टदन
- Medi-Cal: **1-855-839-7613 (TTY 711)**, टदन के चौििस घंटे, सप्ताह के 7 टदन
- िाकी सभी: **1-800-464-4000 (TTY 711)**, टदन के चौििस घंटे, सप्ताह के 7 टदन

**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): យកចិត្តទុកដាក់។** ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចដឹងសំនួរដល់អ្នកបកប្រែ ឬមន្ត្រីអ្នកបកប្រែភាសា សញ្ជាតិ។ អ្នកអាចដឹងសំនួរក្នុងការបកប្រែជាភាសាប្រសិនបើអ្នក ឬមន្ត្រីដទៃទៀតត្រូវបានបញ្ជូនទៅអ្នកសាងសង់ ឬអ្នកសាងសង់។ អ្នកក៏អាចដឹងសំនួរជំនួយប្រចាំថ្ងៃ និងឧបករណ៍ជំនួយនៅតាមក្រុនលែងរបស់យើងផងដែរ។ សមាសភាពសម្រាប់ជំនួយ។ ដល់អ្នកមានជំនួយបាន បិទនៅថ្ងៃឈប់សម្អាតសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815 (TTY 711)** ពីម៉ោង 8 ម៉ោង ០៨ ដល់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ដទៃទៀតៗ **1-800-464-4000 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

**Korean: 안내 사항.** 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7일 오전 8시~오후 8시에 **1-800-443-0815 (TTY 711)** 번으로 문의
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 주 7일, 하루 24시간
- 기타: **1-800-464-4000 (TTY 711)**, 주 7일, 하루 24시간

**Laotian: ໂບດຊາບ.** ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານສາມາດຂໍໃຫ້ແບ່ງປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນໆເຊັ່ນອັກສອນພູມ, ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815 (TTY 711)**, 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

**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 fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc 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.** Tséé' naalkáah sídá'ígíí éí doo t'ée' íl'í' dah sídáa'ígíí. T'ée'góó t'ízi'ígíí éí tséé' naalkáah sídá'ígíí bikáa' dah sídaa'ígíí, t'á'ii bik'eh dah na'álka'ígíí. T'á'ii éí t'ée'góó t'ízi'ígíí bik'eh dah deidiyós, t'á'ii éí bi'ée' bik'eh dah na'álka'ígíí bik'eh dah deidiyós. T'á'ii

bik'eh dah na'alkaigii bikaa' dah na'alkaigii t'aa altso bik'eh dah deidiyos. Bi'ee' naalkaah sida'igii bik'eh ha'a'aah. T'a'ii bik'eh dah na'alkaigii ei bik'eh dah naazhjaa'igii bik'eh dah na'alkaigii.

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

**Punjabi:** ਧਿਆਨ ਧਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਧਿਨਾਂ ਧਿਸੇ ਲਾਗਤ ਵਿੱਚੋਂ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਧਿੱਤੇ ਜਾਣ ਲਈ ਧਿਧਰੁ ਸਿਧਿਓ ਹੋ, ਧਜਸ ਧਵੱਚ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਵਿੱਚੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਧਵੱਚ, ਜਾਂ ਧਿਸੇ ਵੈਲਧਿਧਿ ਫਾਰਮੈਟ ਧਵੱਚ ਅਨੁਵਾਦਿਤ ਿਧਨ ਲਈ ਵੀ ਧਿਧਰੁ ਸਿਧਿਓ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਏਡਜ਼ ਅਤੇ ਉਪਰਨਾਂ ਲਈ ਵੀ ਿੰਨਤੀ ਿਰ ਸਿਧਿਓ ਹੋ। ਮਿਧਿ ਲਈ ਸੁਭ ਮਹਿਨਾ ਿੰਨੀਆਂ ਸੇਵਾਵਾਂ ਵਿੱਚੋਂ ਧਵੱਚਗੇ ਨੂੰ ਿੰਨਲ ਿਰ। ਮਿਧਿ ਿੰਨੀਆਂ ਸੇਵਾਵਾਂ ਵਿੱਚੋਂ ਧਵੱਚਗੇ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲ ਧਿਨ ਿੰਨਲ ਿਰ ਧਵੱਚਗੇ।

- Medicare, ਧਜਸ ਧਵੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815 (TTY 711)**, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਵਿੱਚੋਂ 7 ਧਿਨ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, ਧਿਨ ਵਿੱਚੋਂ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚੋਂ 7 ਧਿਨ
- ਿੰਨਾ ਿੰਨੀ ਸਾਰੇ: **1-800-464-4000 (TTY 711)**, ਧਿਨ ਵਿੱਚੋਂ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚੋਂ 7 ਧਿਨ

**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)**, los 7 días de la semana, 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: โปรดทราบ** มีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815 (TTY 711)** 8.00 น. ถึง 20.00 น. 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613 (TTY 711)** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000 (TTY 711)** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์

**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.