

Southern California Drug Benefit Fund: Kaiser Platinum


The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$300 Individual / \$600 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical Out-of-Pocket Limit: \$2,000 Individual / \$4,000 Family Prescription Drug Out-of-Pocket Limit (in-network): 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 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?	Medical Out-of-Pocket Limit: Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2. Prescription Drug Out-of-Pocket Limit (applicable to prescription drugs from network pharmacies): premiums , deductibles , balance billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

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

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Specialist</u> visit	\$20 / visit, <u>deductible</u> does not apply.	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	20% <u>coinsurance</u> up to \$50 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.optumrx.com or call 1800-788-7871.	Generic drugs	\$8 <u>copay</u> / prescription, <u>deductible</u> does not apply.	Not Covered	<ul style="list-style-type: none"> You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage.
	<u>Formulary</u> brand drugs (Preferred)	\$25 <u>copay</u> / prescription, <u>deductible</u> does not apply.	Not Covered	<ul style="list-style-type: none"> Your <u>cost sharing</u> applies to the <u>prescription drug out-of-pocket limit</u>, not to the medical <u>out-of-pocket limit</u>.
	Non- <u>Formulary</u> brand drugs (Non-Preferred)	\$45 <u>copay</u> / prescription, <u>deductible</u> does not apply.	Not Covered	<ul style="list-style-type: none"> Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications).

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"> • If you purchase a brand drug when a generic drug is available, you pay the brand drug <u>copayment</u> plus the difference in cost between the brand drug and the generic drug, unless your <u>provider</u> indicates “dispense as written.” • Mail order available only outside California. • See the website listed or call 1-800-788-7871 for information on drugs covered by your <u>plan</u>. Not all drugs are covered.
	<u>Preventive care</u> drugs	No charge, <u>deductible</u> 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). <u>Preventive care</u> drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer <u>screening</u> 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 (<u>Specialty drugs</u>)	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	<u>Prior authorization</u> 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 (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)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	\$150 / trip	\$150 / trip	None
	Urgent care	\$20 / visit, deductible does not apply.	Not Covered	Non-Plan providers covered when temporarily outside the service area: \$20 / visit, deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fee	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: \$20 / individual visit, deductible does not apply. 20% coinsurance for other outpatient services; Substance Abuse: \$20 / individual visit, deductible does not apply. 20% coinsurance up to \$5 / day for other outpatient services, deductible does not apply.	Not Covered	Mental / Behavioral Health: \$10 / group visit, deductible does not apply; Substance Abuse: \$5 / group visit, deductible does not apply.
	Inpatient services	20% coinsurance	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, <u>deductible</u> does not apply.	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	20% <u>coinsurance</u>	Not Covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> ; Outpatient: \$20 / visit	Not Covered	None
	<u>Habilitation services</u>	\$20 / visit	Not Covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	100 day limit / benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not Covered	Requires prior authorization.
	<u>Hospice service</u>	No Charge, <u>deductible</u> does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Kaiser: No charge, <u>deductible</u> does not apply. Trust Fund: No charge, <u>deductible</u> does not apply.	Kaiser: Not Covered Trust Fund: No charge, <u>deductible</u> does not apply.	Trust Fund: Maximum benefit of \$135 per exam.
	Children's glasses	Kaiser: Not Covered Trust Fund: You pay all charges over the Fund's allowance, <u>deductible</u> does not apply.	Kaiser: Not Covered Trust Fund: You pay all charges over the Fund's allowance, <u>deductible</u> does not apply.	Trust Fund: <u>Allowed amount</u> 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	Kaiser: Not Covered Trust Fund: You may elect dental coverage from the Indemnity Dental Plan 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 \$120 per calendar year)
● Cosmetic surgery	● Private-duty nursing	● Weight loss programs

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

● Acupuncture (<u>plan provider</u> 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 <u>Plan</u> 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

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

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

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

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$300
Specialist copayment	\$20
Hospital (facility) coinsurance	20%
Other (blood work) copayment	\$10

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

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

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	\$300
Specialist copayment	\$20
Hospital (facility) coinsurance	20%
Other (blood work) copayment	\$10

This EXAMPLE event includes services like:
[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$890
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$1,110

Mia's Simple Fracture

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

The plan's overall deductible	\$300
Specialist copayment	\$20
Hospital (facility) coinsurance	20%
Other (x-ray) copayment	\$10

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

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

**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.

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

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

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
 - ◆ Qualified sign language interpreters
 - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
 - ◆ Qualified interpreters
 - ◆ Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week.
- All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week.

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

How to file a grievance with Kaiser Permanente

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

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at kp.org or call Member Services and ask them to send you a form that you can send back.

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

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

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

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

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

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370 (TTY 711)**
- **By mail:** Fill out a complaint form or send a letter to:

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

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

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

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

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office 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: تُبَيَّنُ المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة، يمكنك طلب وثائق مترجمة بلغتك أو بتصنيع بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرفاقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا 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 բանակը թարգմանության ծառայություններ, այդ թվում ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլնտրանքային 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 7օր
- Medi-Cal՝ **1-855-839-7613 (TTY 711)**, օրը 24ժամ, շաբաթը 7օր
- Մյուս բոլոր՝ **1-800-464-4000 (TTY 711)**, օրը 24ժամ, շաբաթը 7օր

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版本，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 بھرمندی 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 ترجمه شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنیم، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین میتوانید امکانات و دستگاه‌هایی 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 कक्षसी शुल्क के उपिष्ठ है। आप दुभाषण्या सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन **फ़िलैंग वेब** के दुभाषण्ये भी शालमि हैं। आप सामग्रियों को अपनी भाषा या वैकजल्पक प्रारूप, **फ़िलैसे** कक्ष ब्रेंड, ऑडियो, या **फ़िल्ड** एप्रेंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुषवधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा षवभाग को कॉल करें। सदस्य सेवा षवभाग मुख्य छुट्टियों वाली टदन **फ़िल्ड** रहता है।

- Medicare, जिसमें D-SNP शालमि है: **1-800-443-0815 (TTY 711)**, सुहि 8 **फ़िल्ड** से रात 8 **फ़िल्ड** तक, सप्ताह के 7 टदन
- Medi-Cal: **1-855-839-7613 (TTY 711)**, टदन के चौलीस घंटे, सप्ताह के 7 टदन
- छिकी सभी: **1-800-464-4000 (TTY 711)**, टदन के चौलीस 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 koom pab dawb thiab tej koom 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 hnub 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 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000 (TTY 711)**, 24 teev hauv ib hnub, 7 hnub 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おりません。

- 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

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: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍປໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ວຸນໜ້າຍພາສາມີ. ທ່ານສາມາດຂໍໃຫ້ແປໂອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ກູບແບບອື່ນເຊັ່ນອັກສອນນູນ, ສົງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນທ່ານຢັ້ງສາມາດຮ້ອງຂໍເຄື່ອງຈ່ວຍຝັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນຮະຖານທີ່ຂອງພວກເຮົາ. ໂທບາພະແນກບໍລິການວະມາຊີກະຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການວະມາຊີກະມີນີ້ມີບັດໃນວິນພກທີ່ສ້າຄົນຕ່າງໆ.

- Medicare, ວົມທັງ D-SNP: **1-800-443-0815 (TTY 711)**, 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແວງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 ຂື່ວໂມງຕໍ່ມື້, 7 ມີຕໍ່ອາທິດ
- ອິນໄກ: **1-800-464-4000 (TTY 711)**, 24 ຂື່ວໂມງຕໍ່ມື້, 7 ມີຕໍ່ອາທິດ

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 horng 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 sidá'ígíí éí doo tl'ée' ííł'íí dah sidáa'ígíí. Tl'ée'góó tl'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáá' dah sidaaígíí, t'á'ii bik'eh dah na'alkaígíí. T'á'ii éí tl'ée'góó tl'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'ée' bik'eh dah na'alkaígíí bik'eh dah deidiyós. T'á'ii

bik'eh dah na'ałkaígíí bikáá' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'ée' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

- Medicare, bikáá' dah deidiyós D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. góó 8 p.m., 7 jí t'áálá'í damóó
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 t'ohch'oolí t'áálá'í jí, 7 jí t'áálá'í damóó
- T'áá ał'ąą: **1-800-464-4000 (TTY 711)**, 24 t'ohch'oolí t'áálá'í jí, 7 jí t'áálá'í damóó

Punjabi: ਧਿਆਨ ਪਿਛੁ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਧਿਨਾਂ ਪਿਸੇ ਲਾਗੂ ਫੋਨ ਦੇ ਉਪਲਿੰਡਿ ਹੈ। ਤੁਸੀਂ ਹਿੰਦੁਆਂ ਸੇਵਾਵਾਂ ਪਿੱਤੇ ਜਾਣ ਲਈ ਹਿੰਦੁ ਸਿਹਿੰਦੀ ਹੈ, ਧਜਸ ਧਵੱਚ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਫੋਨ ਹਿੰਦੁਆਂ ਸੇਵਾਵਾਂ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮਗਰੀਆਂ ਨੰਦੀਆਂ ਆਪਣੀ ਭਾਸ਼ਾ ਧਵੱਚ, ਜੁਂ ਧਿਸੇ ਵੈਂਲਾਧਪੁ ਫਾਰਮੇਟ ਧਵੱਚ, ਅਨੁਵਾਧਿਤ ਹਿੰਦੁ ਨਾਲ ਲਈ ਵੀ ਹਿੰਦੁ ਸਿਹਿੰਦੀ ਹੈ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਤਾ ਏਡਜ਼ ਅਤੇ ਉਪਰਨੌ ਲਈ ਵੀ ਹਿੰਦੁ ਨਾਲ ਮਿਹਿੰਦੀ ਹੈ। ਮਿਹਿੰਦੀ ਲਈ ਸਾਡੇ ਮੈਂਡੂਰਾਂ ਹਿੰਦੀਆਂ ਸੇਵਾਵਾਂ ਫੋਨ ਧਵਭਾਗ ਨੂੰ ਹਿੰਦੁ ਨਾਲ ਹਿੰਦੀ ਹੈ। ਮੈਂਡੂਰਾਂ ਹਿੰਦੀਆਂ ਸੇਵਾਵਾਂ ਹਿੰਦੀ ਧਵਭਾਗ ਮੁਖ ਛੁਟੀਆਂ ਵਾਲੇ ਧਿਨ ਫੋਨ ਰਧਹੀੰਦਾ ਹੈ।

- Medicare, ਧਜਸ ਧਵੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815 (TTY 711)**, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਤੀ, ਹਫ਼ਤੇ ਫੋਨ 7 ਧਿਨ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, ਧਿਨ ਵਿੰਦੀ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੰਦੀ 7 ਧਿਨ
- ਹਿੰਦੀ ਸਾਰੇ: **1-800-464-4000 (TTY 711)**, ਧਿਨ ਵਿੰਦੀ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੰਦੀ 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 помочь, 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 horas sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000 (TTY 711)**, 24 horas sa isang araw, 7 araw sa isang linggo

Thai: โปรดทราบ มีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษานี้ได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรารา โทรติดต่อฝ่ายบริการสมาชิกของเราราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะมีด ทำการในวันหยุดราชการต่างๆ

- 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 пристройів 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.