KAISER PERMANENTE® : Point-of-Service (POS) Plan

Kaiser Permanente Insurance Company

Coverage for: Individual/Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-800-788-0710 (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 1-800-788-0710 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	KP Plan Provider (HMO Tier): $0; Participating Provider Tier: $500 Individual / $1,000 Family; Non-Participating Provider Tier: $1,000 Individual / $2,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	KP Plan Provider (HMO Tier): $1,500 Individual / $3,000 Family; Participating Provider Tier: $3,000 Individual / $6,000 Family; Non-Participating Provider Tier: $6,000 Individual / $12,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, precertification penalties, balance-billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See www.kp.org/kpic/pos or call 1-800-788-0710 (TTY: 711) for a list of participating providers.	You pay the least if you use a provider in the Kaiser Permanente network (HMO Tier). You pay more if you use a provider in the participating provider tier. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, to be covered at the KP plan provider level (HMO Tier), but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay HMO Tier (You will pay the least)	What You Will Pay Participating Provider Tier (You will pay more)	What You Will Pay Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	$35 / visit, deductible does not apply.	40% coinsurance	None
	Specialist visit	$20 / visit	$35 / visit, deductible does not apply.	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	No Charge, deductible does not apply.	40% coinsurance, deductible does not apply.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	$35 / test, deductible does not apply.	40% coinsurance	None
	Imaging (CT/PET scans, MRI's)	No Charge	$35 / test, deductible does not apply.	40% coinsurance	Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500.

Common Medical Event	Services You May Need	What You Will Pay HMO Tier (You will pay the least)	What You Will Pay Participating Provider Tier (You will pay more)	What You Will Pay Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary More information about MedImpact prescription drug coverage is available at www.kp.org/kpic/pos	Generic drugs	Kaiser Permanente - Retail: $10 / prescription; Mail order: $20 / prescription	MedImpact Retail: $20 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs	Kaiser Permanente - Retail: $30 / prescription; Mail order: $60 / prescription	MedImpact Retail: $40 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs	Kaiser Permanente - Retail: $30 / prescription; Mail order: $60 / prescription	MedImpact Retail: $50 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Specialty drugs	Kaiser Permanente: 20% coinsurance up to $250 / prescription	MedImpact Retail: 30% coinsurance up to $250 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 / procedure	20% coinsurance	40% coinsurance	Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500.
	Physician/surgeon fees	No Charge	20% coinsurance	40% coinsurance	Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500.
If you need immediate medical attention	Emergency room care	$150 / visit	Covered under HMO Tier	Covered under HMO Tier	None
	Emergency medical transportation	$150 / trip	Covered under HMO Tier	Covered under HMO Tier	None
	Urgent care	$20 / visit	20% coinsurance	40% coinsurance	None

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If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	20% coinsurance after $250 / admission	40% coinsurance after $500 / admission	Participating / Non-Participating provider: Precertification required (except for emergencies). Failure to precertify may result in a penalty up to $500.
	Physician/surgeon fee	No Charge	20% coinsurance	40% coinsurance	Participating / Non-Participating provider: Precertification required (except for emergencies, or length of stay following mastectomy/lymph node surgeries). Failure to precertify may result in a penalty up to $500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: $20 / individual visit. No Charge for other outpatient services; Substance Abuse: $20 / individual visit. $5 / day for other outpatient services	$35 / individual visit, deductible does not apply. No Charge for other outpatient services	40% coinsurance / individual visit	KP Plan provider: Mental / Behavioral Health: $10 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$250 / admission	20% coinsurance after $250 / admission	40% coinsurance after $500 / admission	Participating / Non-Participating provider: Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty up to $500.
If you are pregnant	Office visits	No Charge	No Charge, deductible does not apply.	40% coinsurance, deductible does not apply.	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	$250 / admission	20% coinsurance after $250 / admission	40% coinsurance after $500 / admission	Participating / Non-Participating provider: Precertification required (for stays exceeding 48/96 hours for vaginal/caesarean deliveries). Failure to precertify may result in a penalty of up to $500.

Common Medical Event	Services You May Need	What You Will Pay HMO Tier (You will pay the least)	What You Will Pay Participating Provider Tier (You will pay more)	What You Will Pay Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance, deductible does not apply.	20% coinsurance, deductible does not apply.	KP Plan provider: Up to 100 visits / year. Participating / Non-Participating provider: Up to 100 visits combined / year. (Limit does not apply to Treatment of Mental Health and Substance Use Disorders.)
	Rehabilitation services	Inpatient: $250 / admission; Outpatient: $20 / visit	Inpatient: 20% coinsurance after $250 / admission; Outpatient: $35 / visit, deductible does not apply.	Inpatient: 40% coinsurance after $500 / admission; Outpatient: 40% coinsurance	Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500.
	Habilitation services	$20 / visit	$35 / visit, deductible does not apply.	40% coinsurance	Cost share applies to Outpatient services. Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500.
	Skilled nursing care	$250 / admission	20% coinsurance after $250 / admission	40% coinsurance after $500 / admission	Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500. Up to 60 days / benefit period. KP Plan provider: Up to 100 days / benefit period. (The day maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorders.)
	Durable medical equipment	30% coinsurance	30% coinsurance	50% coinsurance	KP Plan provider: Requires prior authorization. Participating / Non-Participating provider: Precertification required. Failure to precertify may result in a penalty up to $500. Up to $2000 limit / year for certain items.
	Hospice service	No Charge	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Not Covered	Limited to one exam per year.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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.)

- Children's glasses
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care (chiropractic/acupunture care limited to 30 visit limit / year)
- Infertility treatment ($1000 limit / Year)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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 (Participating / Non-Participating Provider Tiers)	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare (KP Plan Provider / HMO Tier)	1-888-466-2219 or www.healthhelp.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 1-800-788-0710 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-788-0710 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710 (TTY: 711)

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

The HMO Tier of the Point-of-Service (POS) plan is underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) while the Participating Provider and Non-Participating Provider Tiers of the POS plan are underwritten by Kaiser Permanente Insurance Company (KPIC). KPIC is a subsidiary of KFHP.

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** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$250**
- **Other (blood work) copayment** **$0**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$350**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$250**
- **Other (blood work) copayment** **$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$250**
- **Other (x-ray) copayment** **$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-464-4000** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-251-7052

You may also contact the California Department of Insurance regarding your complaint.

By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Electronically:
www.insurance.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file the complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697(TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios en otros idiomas sin ningún costo. Puede conseguir un intérprete. Puede conseguir que le lean los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-464-4000. Para obtener más ayuda, llame al Departamento de Seguro de CA al 1-800-927-4357. Los usuarios de la línea TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員。您可請人將文件唸給您聽，且您可請我們將您語言版本的部分文件寄給您。如需協助，請致電列於會員卡上的電話號碼或致電 1-800-464-4000 與我們聯絡。如需進一步協助，請致電 1-800-927-4357 與加州保險局 聯絡。聽障及語障電話專線使用者請致電 711。Chinese

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No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Doo bik'é azláágoo Saad Bee Áká Aná'álwo'. Ata' halne'í ná shóidoot'eeł. Nizaad bee naaltsoos nich'į' yídóoltah Shíká i'doolwoł nínízingo éí béésh bee hodíílnih, naaltsoos bee nééhózinígíí bik'ehgo hane'í bikáá' éí doodago kojį' hodíílnih 1-800-464-4000. Nááná łahgo ałdó' shíká i'doolwoł nínízingo kojį' hodíílnih CA Dept. of Insurance bik'ehgo hane'í éí 1-800-927-4357. TTY chodayooł'ígíí éí díí 711. Navajo

Dịch vụ về ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và được người đọc giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Để được giúp đỡ, xin gọi chúng tôi theo số điệnthoại ghi trên thẻ ID hội viên hoặc số 1-800-464-4000. Để được giúp đỡ thêm, vui lòng gọi Bộ Bảo hiểm CA theo số 1-800-927-4357. Người sử dụng TTY gọi số 711. Vietnamese

무료 언어 서비스. 한국어 통역 서비스 및 한국어로 서류를 낭독해 드리는 서비스를 제공하고 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와 있는 전화번호 또는 1-800-464-4000번으로 문의하십시오. 보다 자세한 사항은 캘리포니아 주 보험국, 전화번호 1-800-927-4357번으로 문의하십시오. TTY 사용자 번호 711. Korean

Mga Libreng Serbisyo kaugnay sa Wika. Maaari kayong kumuha ng tagasalin-wika at hingin na basahin sa inyo ang mga dokumento sa sarili ninyong wika. Para humingi ng tulong, tawagan kami sa numerong nakasulat sa inyong ID card o sa 1-800-464-4000. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Dapat tumawag ang mga gumagamit ng TTY sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք օգտվել բանավոր թարգմանչի ծառայություններից և խնդրել, որ փաստաթղթերը Ձեր լեզվով կարդան Ձեզ համար:Օգնության համար զանգահարեք մեզ՝ Ձեր ID քարտի վրա նշված կամ 1-800-464-4000. հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայիապահովագրության դեպարտամենտ՝ 1-800-927-4357. հեռախոսահամարով: TTY -ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги языкового перевода. Вы можете воспользоваться услугами переводчика, при этом документы могут быть зачитаны Вам на Вашем языке. Чтобы получить помощь, позвоните нам по телефону, указанному в Вашей идентификационной карточке участника, или 1-800-464-4000. За дополнительной помощью обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Пользователи TTY, звоните по номеру 711. Russian

無料の言語サービス。通訳に依頼して、日本語で書類を読んでもらうことができます。通訳サービスが必要な際は、ID カードに記載の番号、または 1-800-464-4000 にお電話ください。さらにヘルプが必要な場合は、カリフォルニア州保険庁（1-800-927-4357）にお電話ください。TTY ユーザーの方は、711 にお電話ください。 Japanese

خدمات زبان به صورت رایگان. می توانید از خدمات مترجم شفاهی بهره مند شوید و ترتیب خواندن متن ها برای شما به زبان خودتان را بدهید. برای دریافت کمک و راهنمایی، با ما به شماره ای که روی کارت شناسایی شما قید شده یا 1-800-464-4000 تماس بگیرید. برای دریافت کمک و راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY با شماره 711 تماس حاصل نمایند. Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-464-4000.**'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ, ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ** 1-800-927-4357**'ਤੇ ਫ਼ੋਨ ਕਰੋ।** TTY **ਦੇ ਉਪਯੋਗਕਰਤਾ** 711**'ਤੇ ਫ਼ੋਨ ਕਰੋ।** Punjabi

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន និងឲ្យគេអានឯកសារជូនអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក ឬ 1-800-464-4000.។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ អ្នកប្រើ TTY ហៅលេខ 711។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-464-4000. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم1-800-927-4357. لمستخدمي خدمة الهاتف النصي يرجى الاتصال على 711. Arabic

Cov Kev Pab Txhais Lus Tsis Raug Nqi Dab Tsi Koj muaj tau ib tug neeg txhais lus thiabhais tau kom nyeem cov ntaub ntawv ua koj hom lus rau koj. Xav tau kev pab, hu rau peb ntawm tus xov toojteev muaj nyob rau ntawm koj daim yuaj ID los yog 1-800-464-4000. Xav tau kev pab ntxiv hu rau CA Tuam Tsev Tswj Kev Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

मुफ्त भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और आपको दस्तावेज़ आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-464-4000 पर हमें फोन करें। अधिक सहायता के लिए कैलीफ़ोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर फोन करें। TTY प्रयोक्ता 711 पर फोन करें। Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอรับบริการล่ามแปลภาษาและขอให้อ่านเอกสารให้คุณฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อหาเราตามหมายเลขที่ระบุอยู่บนบัตร ID ของคุณหรือหมายเลข 1-800-464-4000. หากต้องการความช่วยเหลือในเรื่องอื่นๆ เพิ่มเติม โปรดโทรติดต่อฝ่ายประกันโรคมะเร็งที่หมายเลข 1-800-927-4357 ผู้ใช้ TTY โปรดโทรไปที่หมายเลข 711. Thai

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