

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,000 Individual / \$4,000 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?	Yes. Pharmacy Deductible: \$250 Individual / \$500 Family in network. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$7,000 Individual / \$14,000 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 , and health care services this plan ; doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network providers might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45 / visit, deductible does not apply	Not Covered	None
	Specialist visit	\$65 / visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$70 / encounter; Lab tests: \$50 / encounter; deductible does not apply	Not Covered	Lab: \$50 Copayment ; X-Ray and Diagnostic Testing : \$70 Copayment
	Imaging (CT/PET scans, MRI's)	\$350 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at kp.org/formulary.	Generic drugs	Retail: \$20 plan pharmacy; Mail Order: \$40 / prescription	Not Covered	Deductible does not apply. Up to 30-day supply retail and 100-day supply mail order. Subject to formulary guidelines.
	Preferred brand drugs	Retail: \$65 plan pharmacy; Mail Order: \$130 / prescription	Not Covered	After plan deductible , Up to 30-day supply retail and 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs	Retail: \$65 plan pharmacy; Mail Order: \$130 / prescription	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	35% Coinsurance up to \$250 / prescription	Not Covered	After plan deductible , up to 30-day supply. Subject to formulary guidelines.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% Coinsurance	Not Covered	Coinsurance is per procedure and includes the outpatient facility fee and the outpatient surgery physician and surgical service fee.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	\$350 / visit	\$350 / visit	Copayment is waived if admitted to hospital as inpatient.
	Emergency medical transportation	\$250 / trip	\$250 / trip	Copayment is per trip
	Urgent care	\$45 / visit, deductible does not apply	\$45 / visit, deductible does not apply	Urgent care from non-participating providers is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% Coinsurance	Not Covered	Cost-share includes inpatient hospital services fee and inpatient physician and surgical services fee.
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: \$45 / individual visit; No charge for other outpatient services, deductible does not apply Substance Abuse: \$45 / individual visit; No charge for other outpatient services	Not Covered	\$22 / group visit
	Inpatient services	35% 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	Not Covered	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	Not Covered	None
	Childbirth/delivery facility services	35% Coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hour limit/visit, up to 3 visit limit/day, up to 100 visit limit/year
	Rehabilitation services	Inpatient: 35% Coinsurance ; Outpatient: \$45 / visit, deductible does not apply	Not Covered	None
	Habilitation services	Inpatient: 35% Coinsurance ; Outpatient: \$45 / visit, deductible does not apply	Not Covered	None
	Skilled nursing care	35% Coinsurance	Not Covered	Up to 100 days / benefit period
	Durable medical equipment	35% Coinsurance , deductible does not apply	Not Covered	Subject to formulary guidelines
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	No Charge	Not Covered	Coverage is limited to one pair of glasses per year with selection from collection frames.
	Children's dental check-up	No Charge	Not Covered	Limited to two check-ups per year. Covered by Delta Dental.

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 .)		
<ul style="list-style-type: none"> • Chiropractic Care • Cosmetic Surgery • Dental Care (Adult) • Hearing Aids 	<ul style="list-style-type: none"> • Infertility Treatment • Long-Term/Custodial Nursing Home Care • Non-Emergency Care when Traveling Outside the U.S. • Private-Duty Nursing 	<ul style="list-style-type: none"> • Routine Eye Care (Adult) • 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.)		
<ul style="list-style-type: none"> • Abortion 	<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Bariatric Surgery

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

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

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.healthhelp.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
■ The plan's overall deductible \$2,000	■ The plan's overall deductible \$2,000	■ The plan's overall deductible \$2,000
■ Specialist copayment \$65	■ Specialist copayment \$65	■ Specialist copayment \$65
■ Hospital (facility) coinsurance 35%	■ Hospital (facility) coinsurance 35%	■ Hospital (facility) coinsurance 35%
■ Other (blood work) copayment \$50	■ Other (blood work) copayment \$50	■ Other (x-ray) copayment \$70

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

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

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

Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$2000	Deductibles	\$300	Deductibles	\$800
Copays	\$700	Copays	\$1700	Copays	\$500
Coinsurance	\$2500	Coinsurance	\$400	Coinsurance	\$10
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$50	Limits or exclusions	\$0
The total Peg would pay is	\$5260	The total Joe would pay is	\$2450	The total Mia would pay is	\$1310

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

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Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute resolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different dispute resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, MediCal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), MediCal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles (Office for Civil Rights), en ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697(línea TDD). Los formularios de queja formal están disponibles en www.hhs.gov/ocr/office/file/index.html.

Kaiser Permanente 禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計劃成員服務聯絡中心提供語言協助服務；每週七天 24 小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以便您使用本機構的設施與服務。此外，您還可請求以您的語言提供健康保險計劃資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電 **1-800-757-7585**（TTY 專線使用者請撥 **711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用爭議解決方案，請參閱您的《承保範圍說明書》（**Evidence of Coverage**）或《保險證明書》（**Certificate of Insurance**），或者與計劃成員服務代表交談。對於 **Medicare**、**MediCal**、**MRMIP**、**MediCal Access**、**FEHBP** 或 **CalPERS** 計劃成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：

- 於設在本計劃服務設施的某個計劃成員服務處填妥一份《投訴或保險福利索償/請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 將您的冤情申訴書郵寄至設在本計劃服務設施的某個計劃成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 免費致電本機構的計劃成員服務聯絡中心，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）
- 在本機構的網站上填妥一份冤情申訴書，網址是 **kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計劃成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給 **Kaiser Permanente** 的民權事務協調員（**Civil Rights Coordinator**）。您也可與 **Kaiser Permanente** 的民權事務協調員直接聯絡；聯絡地址是 **One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612**。

您還可以採用電子方式透過民權辦公處（**Office for Civil Rights**）的投訴入口網站（**Civil Rights Complaint Portal**）向美國衛生與公共服務部民權辦公處（**U.S. Department of Health and Human Services, Office for Civil Rights**）提出民權投訴，網址是 ocrportal.hhs.gov/ocr/portal/lobby.jsf；或者按照如下聯絡資訊採用郵寄或電話方式聯絡：**U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697**（TDD 專線）。可從網站上下載投訴書，網址是 www.hhs.gov/ocr/office/file/index.html。

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda lingüística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal.

Navajo: Díí éí hane' bítólníihíí át'éego Kaiser Permanente yee nihalne'. Díí hane'ígíí doo hazhó'ó bik'i'diitíhígóó t'áá shóodí koji' hodíílnih **1-800-464-4000** áko saad bee áká i'iilyeed yídííkiil. Kwe'é áká aná'álwo' t'áá álahjí' naadiindíí' ahéé'ílkidgóó dóó tsosts'id jí áá'át'é. Dahodíízingóne' éí dá'deelkaal.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Չանզանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից:

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانه روز و 7 روز هفته، شامل روزهای تعطیل موجود است.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg, tsis xam cov hnuv caiv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、**1-800-464-4000** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

Khmer: នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente ។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000** 'ਤੇ ਫੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรไปยังหมายเลข **1-800-464-4000** เพื่อขอความช่วยเหลือด้านภาษา สามารถโทรติดต่อได้ตลอด 24 ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ.

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