



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 [www.kp.org/plandocuments](http://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](http://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 <a href="#">deductible</a> ?	<a href="#">Participating Provider</a> Tier: \$2,500 Individual / \$5,000 Family. <a href="#">Non-Participating Provider</a> Tier: \$5,000 Individual / \$10,000 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> with <a href="#">out-of-pocket 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?	Yes. \$300 Individual / \$600 Family for brand and <a href="#">specialty prescription drugs</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Participating Provider</a> Tier: \$8,750 Individual / \$17,500 Family. <a href="#">Non-Participating Provider</a> Tier: \$17,500 Individual / \$35,000 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> ?	<a href="#">Premiums</a> , precertification penalties, <a href="#">balance billing</a> charges, and health care services this <a href="#">plan</a> doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.kp.org/sbc/ppo">www.kp.org/sbc/ppo</a> or call 1-800-788-0710 (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 <a href="#">plan's 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 <a href="#">provider's</a> 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> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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		Limitations, Exceptions, & Other Important Information
		Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$55 / visit, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$90 / visit, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening/Immunization</a>	No charge, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	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)	X-ray: \$90 / test, <a href="#">deductible</a> does not apply. Lab tests: \$55 / test, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	\$300 / procedure	40% <a href="#">coinsurance</a>	Precertification required. Failure to precertify may result in a penalty of up to \$500.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/kpic/ppo">www.kp.org/kpic/ppo</a>	Generic drugs	MedImpact: \$19 / <a href="#">prescription</a> (retail), \$38 / <a href="#">prescription</a> (mail order), <a href="#">deductible</a> does not apply	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to <a href="#">formulary</a> guidelines. No charge for contraceptives.
	Preferred brand drugs	MedImpact: \$85 / <a href="#">prescription</a> (retail), \$170 / <a href="#">prescription</a> (mail order), after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to <a href="#">formulary</a> guidelines.
	Non-preferred brand drugs	MedImpact: \$85 / <a href="#">prescription</a> (retail), \$170 / <a href="#">prescription</a> (mail order), after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to <a href="#">formulary</a> guidelines.
	<a href="#">Specialty drugs</a>	MedImpact: 30% <a href="#">coinsurance</a> up to \$250 / <a href="#">prescription</a> , after drug <a href="#">deductible</a>	Not covered	Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required. Failure to precertify may result in a penalty of up to \$500.
	Physician/surgeon fees	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required. Failure to precertify may result in a penalty of up to \$500.
If you need immediate medical attention	<a href="#">Emergency room care</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> waived if admitted to hospital as inpatient.
	<a href="#">Emergency medical transportation</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	\$55 / visit, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required (except for emergencies, or length of stay following mastectomy/lymph node surgeries). Failure to precertify may result in a penalty of up to \$500.
	Physician/surgeon fees	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required (except for emergencies, or length of stay following mastectomy/lymph node surgeries). Failure to precertify may result in a penalty of up to \$500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$55 / individual visit, <a href="#">deductible</a> does not apply. No charge for other outpatient services, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	<a href="#">Participating Provider</a> : \$27 / group visit, <a href="#">deductible</a> does not apply
	Inpatient services	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty of up to \$500.
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply.	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	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Precertification required (for maternity admission stays exceeding 48/96 hours for vaginal/caesarean deliveries). Failure to precertify may result in a penalty of up to \$500.

If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$45 / visit, <a href="#">deductible</a> does not apply.	40% <a href="#">coinsurance</a>	Up to 100 visits combined / year. (Limit does not apply to physical, occupational, and speech therapy visits or to treatment of Mental Health and Substance Use Disorders). Precertification required. Failure to precertify may result in a penalty of up to \$500.
	<a href="#">Rehabilitation services</a>	Outpatient: \$55 / visit, <a href="#">deductible</a> does not apply. Inpatient: 35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification required. Failure to precertify may result in a penalty of up to \$500.
	<a href="#">Habilitation services</a>	Outpatient: \$55 / visit, <a href="#">deductible</a> does not apply. Inpatient: 35% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification required. Failure to precertify may result in a penalty of up to \$500.
	<a href="#">Skilled nursing care</a>	35% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Up to 100 days / benefit period. Precertification required. (The day maximum does not apply to <a href="#">medically necessary</a> treatment of Mental Health and Substance Use Disorders). Failure to precertify may result in a penalty of up to \$500.
	<a href="#">Durable medical equipment</a>	35% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Up to \$2,000 limit / year for certain items. Precertification required. Failure to precertify may result in a penalty of up to \$500.
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	No charge	Limited to 1 exam / year
	Children's glasses	No charge, <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	Limited to 1 pair of glasses/year from select frames and lenses.
	Children's dental check-up	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Limited to 2 check-ups / year

#### Excluded Services & Other Covered Services:

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

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (\$1,000 limit / year)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

**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	1-800-788-0710 (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-EEBSA (6272) 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>

**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)

Traditional Chinese (中文): 如果需要中文的帮助, 請撥打這個號碼 1-800-757-7585 (TTY: 711)

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

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog, tumawag sa 1-800-788-0710 (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 alinis i en Kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

Chamorro (Chamoru): Para un ma ayuda gi finu Chamorro, a'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.*

*The PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (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](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other (blood work) [copayment](#) \$55

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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$2,100
What isn't covered	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$5,050</b>

**Managing Joe's Type 2 Diabetes (a**

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other (blood work) [copayment](#) \$55

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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$1,900
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,400</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$90
- Hospital (facility) [coinsurance](#) 35%
- Other (x-ray) [copayment](#) \$90

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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>

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 **1-800-788-0710** (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**  
**P.O. Box 1809**  
**Pleasanton, CA 94566**  
**Phone: 1-800-788-0710**

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: 1-800-482-4**  
**TDD (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](http://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  
Phone: 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>.

Pending Regulatory Review





خدمات تسهيلات زبانی رایگان. شما می‌توانید مترجم شفاهی بگیرید. می‌توانید درخواست کنید که اسناد برایتان خوانده و بعضی از آنها به زبان خودتان به شما ارسال شود. برای دریافت راهنمایی، با ما به شماره مندرج در زیر یا شماره روی کارت شناسایی‌تان یا 1-800-788-0710 تماس بگیرید. برای کسب راهنمایی بیشتر، با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY می‌توانند با 711 تماس بگیرند. Farsi

ਬਿਨਾ ਲਾਗਤ ਦੀ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਰਾ ਲੈ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਕਿਸੇ ਤੋਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹਾ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਜਾਂ

1-800-788-0710 'ਤੇ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। TTY ਵਰਤੋਂਕਾਰ 711 'ਤੇ ਕਾਲ ਕਰਨ। Punjabi

សេវាភាសាឥតគិតថ្លៃ៖ អ្នកអាចទទួលបានអ្នកបកប្រែ និងឱ្យគេអានឯកសារជូនអ្នក ជាភាសាប្រើ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកកម្រិត ភាសាខ្មែរលេខដែលមានគោក លើប័ណ្ណ ID របស់អ្នក ឬ 1-800-788-0710។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទគោរកស្តងធានារ៉ាប់រង វេបសាយឬទូរស័ព្ទ ភាសាខ្មែរ 1-800-927-4357។ អ្នកក៏ប្រើ TTY គោកលេខ 711។ Khmer

خدمات اللغة بدون تكلفة. يمكنك الحصول على مترجم شفوي وخدمة قراءة المستندات لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج في بطاقة الهوية الخاصة بك أو برقم 1-800-788-0710. لمزيد من المساعدة، اتصل بقسم التأمين بولاية كاليفورنيا على الرقم 1-800-927-4357. يمكنكهم الاتصال برقم 711. Arabic

Cov Kev Pab Cuam Txhais Lus Dawb. Koj tuaj yeem tau txais ib tus neeg txhais lus thiab txais tau cov ntaub ntawm yuaj nyem tag ntawd xa tuaj rau koj muab sau ua koj hom lus xa tuaj Yog xav tau kev pab, hu rau pab ntawm tus xov tooj teev muaj nyob rau ntawm koj daim yuaj ID los yog 1-800-788-0710. Yog xav tau kev pab ntxiv hu rau CA Chaw Ua Hauj Lwm Tswj Kev Tuav Pov Hwm ntawm 1 800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

निःशुल्क भाषा सेवाएं। आप एक दुभाषिया को ले सकते हैं और दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। सहायता के लिए, हमें अपने आईडी कार्ड पर दर्ज नंबर या

1-800-788-0710 पर कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें। ग्रीटीवाई उपयोगकर्ता 711 पर कॉल करें। Hindi

บริการด้านภาษาโดยไม่มีค่าใช้จ่าย คุณสามารถรับคำแปลและรับการอ่านเอกสารให้คุณฟังในภาษาที่คุณต้องการได้ หากต้องการความช่วยเหลือ

โปรดโทรหาเราตามหมายเลขที่ระบุในบัตรประจำตัวประชาชน หรือ 1-800-788-0710 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อฝ่ายประกันภัยของ CA ที่หมายเลข 1-800-927-4357 ผู้ใช้ TTY โทร 711 ภาษาอังกฤษ Thai

Pending Regulatory Review