KAISER PERMANENTE®
Kaiser Permanente Insurance Company : **Bronze 60 PPO 5800/60 PCP + Child Dental INF**

Coverage for: Individual / Family | Plan Type: PPO

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 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?	Participating Provider Tier: $5,800 Individual / $11,600 Family. Non-Participating Provider Tier: $10,800 Individual / $21,600 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?	Yes. $450 Individual / $900 Family for prescription drugs. 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?	Participating Provider Tier: $11,650 Individual / $23,300 Family. Non-Participating Provider Tier: $23,300 Individual / $46,600 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, 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/kpic/ppo or call 1-800-788-0710 (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 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?	No.	You can see the specialist you choose without a referral.

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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 provider's office or clinic	Primary care visit to treat an injury or illness	$60 / visit, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.
	Specialist visit	$100 / visit	100% coinsurance	Participating Provider: Deductible waived for first three visits Non-Participating Provider: Up to out-of-pocket limit.
	Preventive care/screening/ Immunization	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)	X-ray: 40% coinsurance Lab tests: $50 / test, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit
	Imaging (CT/PET scans, MRIs)	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit 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 **prescription drug coverage** is available at www.kp.org/kpic/ppo	Generic drugs	MedImpact: $20 / prescription (retail), $40 / prescription (mail order), deductible does not apply	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Preferred brand drugs	MedImpact: 40% coinsurance up to $500 / prescription, after drug deductible	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines.
	Non-preferred brand drugs	MedImpact: 40% coinsurance up to $500 / prescription, after drug deductible	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines.
	Specialty drugs	MedImpact: 40% coinsurance up to $500 / prescription, after drug deductible	Not covered	Up to a 30-day supply retail. Subject to formulary guidelines.

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
	Physician/surgeon fees	40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Coinsurance waived if admitted to hospital as inpatient.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	$60 / visit, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	100% coinsurance	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. Non-Participating Provider: Up to out-of-pocket limit
	Physician/surgeon fees	40% coinsurance	100% coinsurance	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. Non-Participating Provider: Up to out-of-pocket limit
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 / individual visit, deductible does not apply. No charge for other outpatient services, deductible does not apply.	100% coinsurance	Participating Provider: $30 / group visit, deductible does not apply. Non-Participating Provider: Up to out-of-pocket limit.
	Inpatient services	40% coinsurance	100% coinsurance	Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit.

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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 are pregnant	Office visits	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	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit
	Childbirth/delivery facility services	40% coinsurance	100% coinsurance	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. Non-Participating Provider: Up to out-of-pocket limit
If you need help recovering or have other special health needs	Home health care	40% coinsurance	100% coinsurance	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. Non-Participating Provider: Up to out-of-pocket limit
	Rehabilitation services	Outpatient: $60/ visit, deductible does not apply. Inpatient: 40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
	Habilitation services	Outpatient: $60 / visit, deductible does not apply. Inpatient: 40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
	Skilled nursing care	40% coinsurance	100% coinsurance	Up to 100 days / benefit period. Precertification required. (The day maximum does not apply to medically necessary treatment of Mental Health and Substance Use Disorders). Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
	Durable medical equipment	40% coinsurance	100% coinsurance	Up to $2,000 limit / year for certain items. Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit
	Hospice services	No charge, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit

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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 your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge	Limited to 1 exam / year
	Children's glasses	No charge, deductible does not apply	100% coinsurance	Limited to 1 pair of glasses/year from select frames and lenses. Non-Participating Provider: Up to out-of-pocket limit
	Children's dental check-up	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 2 check-ups / year

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
- Cosmetic surgery
- Dental care (Adult)
- 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
- Bariatric surgery
- Infertility treatment
- 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	1-800-788-0710 (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

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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): 如果需要中文的幫助, 請撥打這個號碼1-800-788-0710 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-278-3296 (TTY: 711).

To see examples of how this plan might cover costs for a simple 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)

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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	$5,800
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other (blood work) copayment	$50

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	$5,800
Copayments	$200
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$7,250**

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

The plan's overall deductible	$5,800
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other (blood work) copayment	$50

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	$300
Copayments	$800
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,800**

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

The plan's overall deductible	$5,800
Specialist copayment	$100
Hospital (facility) coinsurance	40%
Other (*x-ray*) coinsurance	40%

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	$2,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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

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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: 1-800-482-4TDD
(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

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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.

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Notice of Language Assistance

No Cost Language Services. You can get an interpreter and get documents read to you in your language. You may also request for materials to be translated into your language or alternative formats sent to you. For help, call us at the number listed on your ID card or 1-800-788-0710. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios de idioma sin costo. Puede obtener servicios de un intérprete y que le lea documentos en su idioma. También puede solicitar que traduzcan materiales a su idioma o que se le envíen en formatos alternativos. Si necesita ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-788-0710. Para obtener más información, llame al Departamento de Seguros de California al 1-800-927-4357. Los usuarios de TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員並請人使用您的語言將文件唸給您聽。您也可以要求將資料翻譯成您的語言或以替代格式寄給您。如需幫助，請致電您會員證上所列的電話號碼或致電1-800-788-0710與我們聯絡。如需進一步幫助， 請致電1-800-927-4357與加州保險部聯絡。 TTY使用者請致電711。Chinese

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Bizaad bee áko t’áá íiyisí bá oolzinígíí. Díí bizaad bee naaltsoos nihá ályaaígíí t’áá íiyisí yíníłta’go bee hane’ doo naaltsoos nihá níłtsą. Díí naaltsoos nihá bąąh yáhoot’éél doo tł’oh yáti’ígíí éí nihá bąąh yáhoot’éélígíí t’áá íiyisí bee ná’álkidgo nihá dah naashá. Ákót’éego baa ahéél ná’ídlwo’, doo bik’ehgo naaltsoos bee naaznilígíí bikáá’ dah naashá ID béésh bee hane’gi t’áá ájít’éego bee hodíílnih doo 1-800-788-0710 áltsé. Díkwíí hóló holne’go, California Béésh Bee Hane’ Áłchíní Bá Hooghan bee 1-800-927-4357 bibeeso biká anilyeed. TTY yáhoot’éél nihá shikaad 711. Navajo

Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên và người đọc thông tin giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Quý vị cũng có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc gửi đến quý vị các định dạng thay thế. Để được giúp đỡ, hãy gọi chúng tôi theo số điện thoại ghi trên thẻ Nhận Dạng (thẻ ID) của quý vị hoặc số 1-800-788-0710. Để được giúp đỡ thêm, vui lòng gọi Sở Bảo Hiểm CA theo số 1-800-927-4357. Người dùng TTY gọi số 711. Vietnamese

무료 언어 서비스. 통역사를 통해 사용하시는 언어로 서류를 읽어드립니다. 또한 사용하시는 언어로 자료를 번역해달라고 요청하거나 대체 형식으로 보내달라고 요청하셔도 됩니다. 도움이 필요한 경우, 회원 신분증에 적힌 번호나 1-800-788-0710번으로 문의하십시오. 추가로 도움이 필요한 경우, 캘리포니아주 보험국 전화번호 1-800-927-4357번으로 문의하시기를 바랍니다. TTY 사용자는 711번으로 전화하십시오. Korean

Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng interpreter at ipabasa ang mga dokumento sa inyong wika. Maaari rin kayong humiling na ang mga materyal ay isalin sa inyong wika o ipadala sa inyo sa mga alternatibong format. Para sa tulong, tawagan kami sa numero na nakalista sa inyong card ng pagkakakilanlan o sa 1-800-788-0710. Para sa higit pang tulong tumawag sa Departamento ng Insurance ng California sa 1-800-927-4357. Ang mga gumagamit ng TTY ay dapat tumawag sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ, և փաստաթղթերը կարող են ընթերցել ձեզ համար ձեր լեզվով: Կարող եք նաև խնդրել, որ նյութերը թարգմանվեն ձեր լեզվով կամ տրամադրվեն ձեզ այլընտրանքային ձևաչափերով: Օգնության համար զանգահարեք մեզ ձեր նույնականացման քարտի վրա նշված համարով կամ 1-800-788-0710 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության վարչություն 1-800-927-4357 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги переводчика. Вы можете воспользоваться услугами переводчика, и документы будут прочтены для вас на вашем языке. Вы также можете подать запрос о переводе материалов на ваш язык или в альтернативные форматы. Если вам требуется помощь, звоните нам по телефону, указанному на вашей идентификационной карте, или по телефону 1-800-788-0710. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Пользователям TTY следует звонить по телефону 711. Russian

無料の言語サービス。 通訳を手配し、書類をあなたの言語で読み上げてもらうことができます。また、ご希望があれば資料をあなたの言語に翻訳したり、別の形式でお届けすることも可能です。サポートが必要な場合は、身分証明カードに記載されている電話番号、または1-800-788-0710にお電話ください。さらにサポートが必要な場合は、カリフォルニア州保険局まで1-800-927-4357にご連絡ください。TTYユーザーの方は、711までお電話にてご連絡ください。Japanese

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خدمات زبانی رایگان. می‌توانید یک مترجم شفاهی داشته باشید و ترتیبی بدهید تا اسناد به زبان خودتان برای شما خوانده شود. همچنین می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شود یا در قالب‌های جایگزین برای شما ارسال گردد. برای دریافت کمک و راهنمایی، با شماره مندرج در کارت شناسایی یا 1-800-788-0710 با ما تماس بگیرید. برای دریافت راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY می‌توانند با شماره 711 تماس بگیرند. Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸਹਾਇਤਾ ਨਾਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹਵਾ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਜਾਂ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟਾਂ ਦੀ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਸਹਾਇਤਾ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਜਾਂ 1-800-788-0710 'ਤੇ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫ਼ੋਨ ਕਰੋ। ਪੰਜਾਬੀ Punjabi

សេវាកាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែនិងទទួលបានឯកសារអានជូនអ្នក ក្នុងភាសារបស់អ្នក។ អ្នកក៏អាចស្នើសុំព័ត៌មានជាច្រើនដើម្បីបកប្រែក្នុងភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀត ត្រូវបានផ្ញើទៅអ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកលេខដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬនៅលេខ 1-800-788-0710។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅនាយកដ្ឋានជានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាលេខ 1-800-927-4357។ អ្នកប្រើប្រាស់ TTY សូមហៅទៅលេខ 711។ Khmer

خدمات لغوية بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك بلغتك. يجوز لك أيضاً طلب إرسال وثائق مترجمة بلغتك أو صيغ بديلة. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية الخاصة بك أو 1-800-788-0710 . لمزيد من المساعدة اتصل بقسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. على مستخدمي TTY الاتصال على الرقم 711. العربية. Arabic

Kev Pab Txhais Lus Dawb. Koj tuaj yeem txais ib tug kws txhais lus thiab txais kev nyeem cov ntaub ntawv ua koj hom lus. Koj tuaj kheev thov kom muab cov ntaub ntawv txhais mus ua koj hom lus los sis xa ua lwm hom ntawv tuaj rau koj huv si. Yog xav tau kev pab, hu rau nyob ntawm tus xov tooj uas sau nyob rau ntawm koj daim npav cim thawj los sis 1-800-788-0710. Rau 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

बिना किसी लागत के भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और दस्तावेज़ आपको आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। आप सामग्रियों को अपनी भाषा या आपको भेजे जाने वाले वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी अनुरोध कर सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-788-0710 पर हमें कॉल करें। अधिक सहायता के लिए कैलिफोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर कॉल करें। TTY प्रयोक्ता 711 पर कॉल करें। हिंदी: Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอใช้บริการล่ามและบริการอ่านเอกสารให้ฟังเป็นภาษาของคุณได้ คุณอาจขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นที่ส่งถึงคุณได้ หากต้องการความช่วยเหลือ โปรดติดต่อหมายเลขโทรศัพท์ที่ปรากฏบนบัตรประจำตัวของคุณหรือติดต่อหมายเลข 1-800-788-0710 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อกรมการประกันภัยของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 ผู้ใช้เครื่อง TTY โปรดติดต่อหมายเลข 711 Thai

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