



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling **1-855-249-5018**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See Chart on Page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, \$25/individual \$0/family for Adult Dental (Plan Providers) ; Yes, \$50 individual \$0/family for Adult Dental (Non-Plan Providers) 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.
Is there an out-of-pocket limit on my expenses?	Yes. \$1,500 person/\$3,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges (unless balance-billing is prohibited), and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of plan providers, see www.kp.org or call 1-855-249-5018.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes. Written approval is required to see most specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Questions: Call 1-855-249-5018, 1-301-879-6380 (TTY/TDD) or visit us at www.kp.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5018 to request a copy.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., 2101 East Jefferson Street, Rockville, MD 20852



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 per visit	Not covered	Waived for child under age 5
	Specialist visit	\$40 per visit	Not covered	_____none_____
	Other practitioner office visit	\$40 per visit for acupuncture; \$40 per visit for chiropractic care	Not covered	Coverage is limited to 30 visits per year
	Preventive care/ screening/ immunization	No charge	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	_____none_____
	Imaging (CT/PET scans, MRI's)	\$75 per test	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.kp.org.</p>	Generic drugs	\$15 per prescription at Plan Pharmacy; \$20 per prescription at Participating Pharmacy; \$13 per prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
	Preferred brand drugs	\$25 per prescription at Plan Pharmacy; \$45 per prescription at Participating Pharmacy; \$23 per prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
	Non-preferred brand drugs	\$40 per prescription at Plan Pharmacy; \$60 per prescription at Participating Pharmacy; \$38 per prescription through Mail Order	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order. No charge for preventive drugs or contraceptives.
<p>If you have outpatient surgery</p>	Specialty drugs	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	Up to a 30-day supply; Up to a 90-day supply for 3 copays at Plan and Participating Pharmacies; Up to a 90-day supply for 2 copays through Mail Order.
	Facility fee (e.g., ambulatory surgery center)	\$75 per visit	Not covered	_____none_____
	Physician/surgeon fees	Included in facility fee	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$75 per visit	\$75 per visit	Waived if admitted as inpatient
	Emergency medical transportation	\$50 per encounter	\$50 per encounter	_____none_____
	Urgent care	\$40 per visit	\$40 per visit	Non-plan providers are covered only outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 per admission	Not covered	Emergency admissions covered for non-plan providers
	Physician/surgeon fee	Included in facility fee	Not covered	Emergency services covered for non-plan providers
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 per individual visit; \$12 per group visit	Not covered	No coverage for psychological testing for ability, aptitude, intelligence or interest.
	Mental/Behavioral health inpatient services	\$300 per admission	Not covered	_____none_____
	Substance use disorder outpatient services	\$25 per individual visit; \$12 per group visit	Not covered	_____none_____
	Substance use disorder inpatient services	\$300 per admission	Not covered	_____none_____
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy
	Delivery and all inpatient services	\$300 per admission	Not covered	_____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	_____none_____
	Rehabilitation services	\$300 per inpatient admission; \$40 per outpatient visit	Not covered	Outpatient: Limited to 90 consecutive days of treatment per injury, incident or condition per year
	Habilitation services	\$300 per inpatient admission; \$40 per outpatient visit	Not covered	For children under age 3.
	Skilled nursing care	\$300 per admission	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	No charge	Not covered	_____none_____
	Hospice service	No charge	Not covered	_____none_____
	Eye exam	\$25 per Optometrist visit; \$40 per Ophthalmologist visit	Not covered	_____none_____
If your child needs dental or eye care	Glasses	No charge	Not covered	1 pair of glasses per year limited to single or bifocal lenses or 1st purchase of contact lenses per year or 2 pair per eye per year medically necessary contacts (from select group of frames and contacts)
	Dental check-up	No charge	Not covered	No charge applies to preventative services. Discount fees apply to other services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Hearing aids | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine Foot Care |
|--|--|---|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Chiropractic care | <ul style="list-style-type: none">• Dental care (Adult)• Infertility treatment | <ul style="list-style-type: none">• Routine eye care (Adult)• Weight loss programs |
|---|---|---|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-865-5813. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance at 1-877-310-6560 or <http://www.scc.virginia.gov/boi>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-855-249-5018**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-249-5018**
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-855-249-5018**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-855-249-5018**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7,020
- **Patient pays** \$520

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient Pays:

Deductibles	\$20
Copays	\$300
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$520

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,395
- **Patient pays** \$1,005

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient Pays:

Deductibles	\$25
Copays	\$900
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,005

Total amounts above are based on subscriber only coverage

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Kaiser Foundation Health Plan of the of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call the number provided below.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
TTY	711

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. 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 <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>.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic)

ያለምንም ከፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኪስር ፕሮግራምዎ Kaiser Permanente ስለሚያገኙት ሽፋን ማግኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሱ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሱው የስልክ ቁጥር ለኩቱትዎ ወይም ለክልልዎ ደውለው ከሌሎች ርዳኞች ጋር ይነጋገሩ።

العربية (Arabic)

لك الحق في الحصول على المساعدة بلسانك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها لك Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian)

Դուք ունեք Ձեր լեզվով անվճար օգնություն և Դուք ունեք Ձեր ծածկույթի վերաբերյալ, կամ եթե ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի վիզոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործադրություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsòò Wùdù (Bassa)

○ mò nì kpé bɛ̀ m̀ ké gbo-kpá-kpá dyé qé nì miòùn nìin bídǐ-wùdù mú pídyi. ○ jù ké m̀ dyi dyi-dìè-qè bɛ̀ bédé bá nì cèè-qè m̀ tò bò qe zò jè dyiɛ ní, m̀oo jù bá nì kùùm kpɔ̀ jè dyi dyiùn qé Kaiser Permanente múɛ ní, m̀oo ɔ̀ dyi bɔ̀ qò jù bɛ̀ m̀ ké qe qò nyu bò wé jéé qò kò nì, nìí, qá nòbà bɛ̀ wa tòà bò nì bódòò m̀oo nì gbèèè biìe, ké nì mu nyo-wuquùn-zà-nyò qò gbo wùdùùn.

বাংলা (Bengali)

বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente -এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

Cebuano (Bisaya)

Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtagwag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

California.....	1-800-464-4000
Colorado.....	1-800-632-9700
District of Columbia.....	1-800-777-7902
Georgia.....	1-888-865-5813
Hawaii.....	1-800-966-5955
Maryland.....	1-800-777-7902
Oregon.....	1-800-813-2000
Virginia.....	1-800-777-7902
Washington.....	1-800-813-2000
TTY.....	711

中文 (Chinese)

您有權免費以您的語言獲得幫助。如果您對您的 Kaiser Permanente 申請或承保有任何疑問，或者如果您本通知要求在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chuukese)

Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin e erenuk pwe kopwe fori pwan ekoch fofor, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French)

Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German)

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati)

તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાની અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમા તમને કોઈચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole)

Ou gen dwa pou jwenn ed nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè avan yon sètèn dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian)

He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalama kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi)

आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong)

Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseeg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo)

I nwere ikike inweta enyemaka n'asụsụ gi na akwughị ụgwọ ọ bụla. Ọ bụrụ na i nwere ajụjụ gbasara akwụkwọ anamachọihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke a bụ ọkwa a chọrọ ka i mee ihe tupu otu ụbọchi, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi jiri kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano)

Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumannan a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian)

Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese)

あなたは、費用負担なしでご利用の言語で支援を受ける権利を保持しています。お申し込みまたは Kaiser Permanente の担保範囲に関して質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer)

អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសា បស្ចឹម ដោយឥតគិតថ្លៃ។ បស្ចឹមមានសណ្តាប់ មួយអំពី ពាក្យស្នើសុំ ឬការជំនាញបំបែកផ្លូវ។
Kaiser Permanente ឬប្រសិទ្ធិ: គឺជាលិខិត ជូនដំណឹងដែលត្រូវឱ្យអ្នកចាកចោយការត្រឹម កាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបាន ផ្តល់ជូនសម្រាប់ ឬក៏បស្ចឹមបស្ចឹមយាយទៅ កាន់អ្នកបកប្រែ។

한국어 (Korean)

귀하에게는 한국어 통역서비스를 무료로 받을 수 있는 권리가 있습니다.
Kaiser Permanente 를 통한 귀하의 보힘 신청 서나 보힘 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날까지 조취 를 취해야만 하는 경우, 귀하의 주 및 지역의 제 공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian)

ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຂ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໂດຍບໍ່ເສັງຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການ ສະໜັບສະໜູນ ທີ່ ການຄົມຂອງພວມ Kaiser Permanente. ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ ສູງກວ່າໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີ່ໃຈຈະຈົງ ໃດໜຶ່ງ, ໃຫ້ໃບຕາມພາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດ ຂອງທ່ານ ເພື່ອຂໍລິມັດນາຍພາສາ.

Kajin Majöl (Marshallese)

Ewör jimwe eo am in bök jipañ ilo kajin eo am ejjelok wōñān. Ne ewör am kajitök kōn peba in aplaiki eo am ak insurance eo am jān Kaiser Permanente, ak ñe enaan in köjeļä in ej aikuj bwe kwōn ñakūtüt mokta jān juon raan eo emōj an kallikkar, kaļok nōmba eo ej leļok ñan state eo am ak jikūm bwe kwōn maron kōnono ippān juon ri-ukōt.

Naabeehó (Navajo)

T'áá ni nizaad bee níká i' doolwoł doo bik'é asinííáágoó éí bee náhaz'á. Kaiser Permanente áká aná'á'lwó' ná bik'é áziáadoo yínikeedgo naaltsoos hadinílaa, éí bína' ídítikid doogo, éí doodago díí naaltsoos haa'ída yookáalgo hait'áoda í' dítííít níniigo éí nitsaa haboodzojį éí doodago t'áá aadi nahós'a'di ata' dahalne' ígít bich' i' hólné' go bee bíí ahít hodííínih.

नेपाली (Nepali)

तपाईंसग कलै शुल्क नदिइ आपलो भाषामा सहायता पाउनै अधिकार छ । तपाईंसग आपलो आवदन बारे वा Kaiser Permanente मार्फत कवरैज बारेमा कलै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कलै निर्धारित मितिमा कलै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोआबसग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo)

Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiiif kenname biibuudhaan turjumaana haasofsii.

فارسی (Persian)

شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian)

Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahh me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaiang owmi tungoal soun kawehwe.

Portugués (Portuguese)

Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi)

ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਵੱਲੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਆਰੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian)

Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru a statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian)

У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan)

E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le tofogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota'i i se faailiui.

Español (Spanish)

Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog)

Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai)

ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan)

'Oku 'i ai ho totonu keke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisiaua 'a e Kaiser Permanente, pea kapau ko e tohini 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian)

У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

Urdu (Urdu)

آپ کو کوئی بھی قیمت ادا کرنے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا کسی متعلقہ چیز کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کیے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese)

Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba)

O ní ètò láti rí iránlọwọ gbà nipa èdè rẹ láisán owó. Bí o bá ní ibeèrè nipa iwé tí o kọ tàbí ìṣedédéé nípaṣẹ́ Kaiser Permanente, tàbí ifitonilẹ́tí yí jẹ́ èyí o nílò láti igbésẹ́ kan ní ojú kan patọ́, pé nọmbà tí a pèsè fún ipinlẹ́ tàbí agbègbè rẹ láti bá òhògbifọ́ kan sọrọ́.