

Disclosure Form Part One

8390 Rossmoor Walnut Creek
Home Region: Northern California
1/1/27 through 12/31/27

Principal benefits for Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO

"Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. For a complete explanation, please refer to the EOC.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for Covered Benefits you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$6,000	\$6,000	\$12,000
Plan Deductible	\$3,500	\$3,500	\$7,000
Drug Deductible	Not applicable	Not applicable	Not applicable

Plan Provider Office Visits

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits.....	\$30 per visit after Plan Deductible
Most Physician Specialist Visits	\$50 per visit after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (up to and including 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Most urgent care consultations, evaluations, and treatment.....	\$30 per visit after Plan Deductible
Most physical, occupational, and speech therapy.....	\$30 per visit after Plan Deductible

Telehealth Visits

You Pay

Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone.....	No charge after Plan Deductible
Physician Specialist Visits by interactive video or telephone	No charge after Plan Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	30% Coinsurance after Plan Deductible
Most immunizations (including the vaccine).....	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the EOC	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans.....	30% Coinsurance after Plan Deductible

Hospital Inpatient Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible
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Emergency Services and Care

You Pay

Emergency department visits	30% Coinsurance after Plan Deductible
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Note: If you are admitted directly to the hospital as an inpatient for Covered Benefits, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services

You Pay

Ambulance services	30% Coinsurance after Plan Deductible
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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 <https://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 ?		\$3,500 Individual / \$7,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?		Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?		No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?		\$6,000 Individual / \$12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?		Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
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 provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions		Answers	Why this Matters:
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	\$30 / visit	Not Covered	None
	Specialist visit	\$50 / visit	Not Covered	None
	Preventive care/screening/immunization	No Charge, deductible does not apply.	Not Covered	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)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	30% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	Retail: \$15 / prescription ; Mail order: \$30 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	30% coinsurance up to \$250 / prescription	Not Covered	Up to a 30-day supply retail. 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)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	\$30 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: \$30 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fee	30% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: \$15 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	30% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge, deductible does not apply.	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	30% coinsurance	Not Covered	None
	Childbirth/delivery facility services	30% 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 need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: 30% coinsurance ; Outpatient: \$30 / visit	Not Covered	None
	Habitatation services	\$30 / visit	Not Covered	None
	Skilled nursing care	30% coinsurance	Not Covered	100 day limit / benefit period.
	Durable medical equipment	30% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam, deductible does not apply.	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)	
<ul style="list-style-type: none"> Children's glasses Cosmetic surgery Dental Care (Adult & Child) 	<ul style="list-style-type: none"> 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.)	
<ul style="list-style-type: none"> Acupuncture (plan provider referred) Bariatric surgery 	<ul style="list-style-type: none"> Chiropractic care (20 visit limit / year) 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	1-800-278-3296 (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.ccoio.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.dmhca.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet 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)

TRADITIONAL 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)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (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 (Kapasał Falawasch): ngere aukke ghut alillis reel kapasał Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, 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.

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	\$3,500	■ The plan's overall deductible	\$3,500	■ The plan's overall deductible	\$3,500
■ Specialist copayment	\$50	■ Specialist copayment	\$50	■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%	■ Hospital (facility) coinsurance	30%
■ Other (blood work) copayment	\$10	■ Other (blood work) copayment	\$10	■ Other (x-ray) copayment	\$10
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay: Cost Sharing		In this example, Joe would pay: Cost Sharing		In this example, Mia would pay: Cost Sharing	
Deductibles	\$3,500	Deductibles	\$1,200	Deductibles	\$2,800
Copayments	\$10	Copayments	\$600	Copayments	\$0
Coinsurance	\$1,900	Coinsurance	\$200	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$50	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$5,460	The total Joe would pay is	\$2,000	The total Mia would pay is	\$2,800

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

Nondiscrimination Notice

In this document, “we,” “us,” or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at kp.org.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
 - ◆ Qualified sign language interpreters
 - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- 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 our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY 711), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY 711), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY 711), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at kp.org or call Member Services and ask them to send you a form that you can send back.

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
 Member Relations Grievance Operations
 P.O. Box 939001
 San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY 711)
- **By mail:** Fill out a complaint form or send a letter to:

Office of Civil Rights
 Department of Health Care Services
 P.O. Box 997413, MS 0009
 Sacramento, CA 95899-7413

California Department of Health Care Services Office for Civil Rights Complaint forms are available at:
http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY 711 or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201

U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at:
<https://www.hhs.gov/ocr/office/file/index.html>

- Online: Visit the Office for Civil Rights Complaint Portal at: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member Services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week
- All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية الفورية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل بقسم خدمات الأعضاء (Member Services) لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815 (TTY 711)**، 8 صباحًا إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal على: **1-855-839-7613 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعًا: **1-800-464-4000 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՐՀԱՄԱՆՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժինը (Member Services): Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815 (TTY 711)**, 8 a.m.-to 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613 (TTY 711)**, օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը **1-800-464-4000 (TTY 711)**, օրը 24 ժամ, շաբաթը 7 օր

Chinese : 请注意。 我们可及时提供免费语言协助。您可以要求获取口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部 (Member Services) 以获取帮助。重要节假日期间会员服务不开放。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP : **1-800-443-0815 (TTY 711)**，每周 7 天，上午 8 点至晚上 8 点
- 加州医疗保险辅助计划 : **1-855-839-7613 (TTY 711)**，每周 7 天，每天 24 小时
- 所有其他保险计划 : **1-800-757-7585 (TTY 711)**，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهر ممتدی از مساعدت زبانی بموقع به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه شده به زبان خونتان یا در قالب های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای (Member Services) تماس بگیرید. خدمات اعضای، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP : **1-800-443-0815 (TTY 711)**، از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal : **1-855-839-7613 (TTY 711)**، در 24 ساعت شبانه روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر : **1-800-464-4000 (TTY 711)**، در 24 ساعت شبانه روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर दी जाने वाली भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंग्वेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग (Member Services) को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815 (TTY 711)**, सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613 (TTY 711)**, दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000 (TTY 711)**, दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb ncau sij hawm rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab (Member Services). Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815 (TTY 711)**, 8 teev sawv ntov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000 (TTY 711)**, 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese : ご注意。 必要に応じた言語サポートを、無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービス (Member Services) は主要な休日では営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815 (TTY 711)**、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613 (TTY 711)**、24 時間、年中無休

- その他全て: **1-800-464-4000 (TTY 711)**、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។ ជំនួយភាសាមានពេលវេលាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែ ភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្នាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំ ជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែក សេវាសមាជិក (Member Services) របស់យើងសម្រាប់ជំនួយ។ សេវា សមាជិកត្រូវបានបិទនៅ ថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare រួមទាំង D-SNP: **1-800-443-0815 (TTY 711)** ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀតទាំងអស់: **1-800-464-4000 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

Korean: 안내 사항. 시기적절한 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7일 오전 8시~오후 8시에 **1-800-443-0815 (TTY 711)** 번으로 문의
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 주 7일, 하루 24시간
- 기타 모두: **1-800-464-4000 (TTY 711)**, 주 7일, 하루 24시간

Laotian: ໂປດຂອງ, ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງກວ້າງຂວາງໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການພາສາ, ລວມທັງພາສາລາວ, ທ່ານສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນ ພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ, ເຊັ່ນ: ອັກສອນພູມ, ສັງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍ ຟັງ ແລະ ອປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815 (TTY 711)**, 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: **CAU FIM JANGX LONGX OC.** Ninh mbuo duqv jiepv sih liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngx jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem nijec zorc baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn Ziux Goux Baengc Mienh Nyei Dorngx (Member Services) liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gincg nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815 (TTY 711)**, yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaih zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613 (TTY 711)**, yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaih zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000 (TTY 711)**, yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaih zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍLTIIH. T'áá Áko T'áá Altso K'ad Díí T'áá Bini' dée'go Bizaad Bee Na'anish Béchózin, Doo Béeso Bee Na'al'a' Da. T'í'ée'góó t'í'izi'ígíí éí tséé' naalkáah síd'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'al'kaaígíí. T'á'ii éí t'í'ée'góó t'í'izi'ígíí bik'eh dah deidiyós, t'á'ii éí bi'ée' bik'eh dah na'al'kaaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'al'kaaígíí bikáa' dah na'al'kaaígíí t'áá altso bik'eh dah deidiyós. Nihí Diné Bináhásdzáí Baa Anááł'í'ígíí Na'anish (Member Services) Bá Haz'á Bii' Bee Aká Shich'í' Hodiilnih. Dinéelchí Na'anish Bá Haz'á Éí 'Ayóó'át'éego Níheezhch'íjigo Yáá'ah Nits'ááh Daaztsáát.

- Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 t'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá al'áq: **1-800-464-4000 (TTY 711)**, 24 t'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਫਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815 (TTY 711)**, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные и своевременные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815 (TTY 711)**, без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000 (TTY 711)**, круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815 (TTY 711)**, de 8 a. m. a 8 p. m., los 7 días de la semana.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616 (TTY 711)**, las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na mabilis na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: สงสัย มีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านแบบทันทีโดยไม่ต้องไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษาเมื่อใดที่ท่านสามารถขอแปลเอกสาร เป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ฟิล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิก (Member Services) ของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะเปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น. หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần

Disclosure Form Part One

Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items (Tier 1) at a Plan Pharmacy	\$15 for up to a 30-day supply after Plan Deductible
Most generic (Tier 1) refills through our mail-order service	\$30 for up to a 100-day supply after Plan Deductible
Most brand-name items (Tier 2) at a Plan Pharmacy	\$35 for up to a 30-day supply after Plan Deductible
Most brand-name (Tier 2) refills through our mail-order service	\$70 for up to a 100-day supply after Plan Deductible
Most specialty items (Tier 4) at a Plan Pharmacy	30% Coinsurance (not to exceed \$250) for up to a 30-day supply after Plan Deductible

Durable Medical Equipment (DME)

You Pay

DME items as described in the <i>EOC</i>	30% Coinsurance after Plan Deductible
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Mental Health Services

You Pay

Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$30 per visit after Plan Deductible
Group outpatient mental health treatment	\$15 per visit after Plan Deductible

Substance Use Disorder Treatment

You Pay

Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	\$30 per visit after Plan Deductible
Group outpatient substance use disorder treatment	\$5 per visit after Plan Deductible

Home Health Services

You Pay

Home health care (up to 100 visits per Accumulation Period)	No charge after Plan Deductible
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Other

You Pay

Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge after Plan Deductible
Fertility Services, such as outpatient procedures or laboratory tests, as described in the <i>EOC</i> (see <i>EOC</i> for benefit limits)	The Cost Share you would pay if the services were to treat any other condition

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Covered Benefits, principal exclusions, and important notices. To view or download a copy, go to kp.org/choosekp or call Member Services at 1-800-464-4000 (TTY users call 711).