



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/](http://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 <a href="#">deductible</a> ?                                | \$0                                                                                                                                     | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable.                                                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$1,500 Individual / \$3,000 Family                                                                                                     | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes, but you may self-refer to certain <a href="#">specialists</a> .                                                                    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                   | Primary care visit to treat an injury or illness       | \$10 / visit                                             | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                 | <a href="#">Specialist</a> visit                       | \$10 / visit                                             | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                 | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                | Not Covered                                                 | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                            |
| <b>If you have a test</b>                                                                                                                                                                                       | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No Charge                                                | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                 | Imaging (CT/PET scans, MRI's)                          | No Charge                                                | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs (Tier 1)                                 | \$5 / <a href="#">prescription</a>                       | Not Covered                                                 | Up to a 100-day supply retail and mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives.                                                                                                                           |
|                                                                                                                                                                                                                 | Preferred brand drugs (Tier 2)                         | \$15 / <a href="#">prescription</a>                      | Not Covered                                                 | Up to a 100-day supply retail and mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives.                                                                                                                           |
|                                                                                                                                                                                                                 | Non-preferred brand drugs (Tier 2)                     | \$15 / <a href="#">prescription</a>                      | Not Covered                                                 | The <a href="#">cost sharing</a> for non-preferred brand drugs under this <a href="#">plan</a> aligns with the <a href="#">cost sharing</a> for preferred brand drugs (Tier 2), when approved through the <a href="#">formulary</a> exception process. |
|                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a> (Tier 4)               | \$15 / <a href="#">prescription</a>                      | Not Covered                                                 | Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)         | \$10 / procedure                                         | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                 | Physician/surgeon fees                                 | No Charge                                                | Not Covered                                                 | Physician/surgeon fees are included in the Facility fee.                                                                                                                                                                                               |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay Plan Provider<br>(You will pay the least)      | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                   |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$50 / visit                                                     | \$50 / visit                                                   | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | No Charge                                                        | No Charge                                                      | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | \$10 / visit                                                     | Not Covered                                                    | <a href="#">Non-Plan providers</a> covered when temporarily outside the service area: \$10 / visit.                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No Charge                                                        | Not Covered                                                    | None                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fee                            | No Charge                                                        | Not Covered                                                    | None                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$10 / individual visit. No Charge for other outpatient services | Not Covered                                                    | \$5 / group visit.                                                                                                                                                                                                                      |
|                                                                           | Inpatient services                               | No Charge                                                        | Not Covered                                                    | None                                                                                                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                                    | No Charge                                                        | Not covered                                                    | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | No Charge                                                        | Not Covered                                                    | None                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services            | No Charge                                                        | 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                   |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge                                                | Not Covered                                                 | 2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.      |
|                                                                       | <a href="#">Rehabilitation services</a>   | Inpatient: No Charge; Outpatient: \$10 / visit           | Not Covered                                                 | None                                                                    |
|                                                                       | <a href="#">Habilitation services</a>     | \$10 / visit                                             | Not Covered                                                 | None                                                                    |
|                                                                       | <a href="#">Skilled nursing care</a>      | No Charge                                                | Not Covered                                                 | 100 day limit / benefit period.                                         |
|                                                                       | <a href="#">Durable medical equipment</a> | No Charge                                                | Not Covered                                                 | Requires prior authorization.                                           |
|                                                                       | <a href="#">Hospice service</a>           | No Charge                                                | Not Covered                                                 | None                                                                    |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No Charge for refractive exam                            | Not Covered                                                 | None                                                                    |
|                                                                       | Children's glasses                        | No Charge                                                | Not Covered                                                 | Up to \$150 glasses or contact lenses (instead of glasses) / 24 months. |
|                                                                       | Children's dental check-up                | Not Covered                                              | Not Covered                                                 | None                                                                    |

**Excluded Services & Other Covered Services:**

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

| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b> |                                                                                                                                                            |                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture (plan provider referred)</li> <li>• Bariatric surgery</li> </ul>               | <ul style="list-style-type: none"> <li>• Chiropractic care (30 visit limit / year)</li> <li>• Hearing aids (\$1000 limit / ear every 36 months)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul> |

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

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

**Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:**

|                                                                                              |                                                                                                           |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Kaiser Permanente Member Services                                                            | 1-800-278-3296 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>     |
| Department of Labor’s Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| California Department of Insurance                                                           | 1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                   |
| California Department of Managed Healthcare                                                  | 1-888-466-2219 or <a href="http://www.dmhc.ca.gov">www.dmhc.ca.gov</a>                                    |

**Does this plan provide Minimum Essential Coverage? Yes.**

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

**Does this plan meet the Minimum Value Standards? Yes.**

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

**Language Access Services:**

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

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

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

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

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



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

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other (blood work) [copayment](#) \$0

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

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$10            |
| <a href="#">Coinsurance</a>            | \$0             |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$50            |
| <b>The total Peg would pay is</b>      | <b>\$60</b>     |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other (blood work) [copayment](#) \$0

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

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$400</b>   |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other (x-ray) [copayment](#) \$0

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

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$100          |
| <a href="#">Coinsurance</a>            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$100</b>   |

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

## Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente<sup>1</sup> follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully 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:

- 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 Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY 711)
- All others: **1-800-464-4000** (TTY 711)

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

### How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente 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:** Medi-Cal members may call **1-855-839-7613** (TTY 711). All other members may call **1-800-464-4000** (TTY 711). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at [kp.org](http://kp.org) or call Member Services and ask them to send you a form that you can send back.

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<sup>1</sup> Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **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](http://kp.org/facilities) for addresses)
- **Online:** Use the online form on our website at [kp.org](http://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 of Civil Rights *(For Medi-Cal Beneficiaries Only)***

You can also file a civil rights complaint with the California Department of Health Care Services Office of 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:  
Deputy Director, Office of Civil Rights  
Department of Health Care Services  
Office of Civil Rights  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413

Complaint forms are available at: [http://www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)

- **Online:** Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov)

#### **How to file a grievance with the U.S. Department of Health and Human Services Office of 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

Complaint forms are available at:  
<https://www.hhs.gov/ocr/complaints/index.html>

- **Online:** Visit the Office of Civil Rights Complaint Portal at:  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.



## Language Assistance Services

**English:** Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613 (TTY 711)**
- All others: **1-800-464-4000 (TTY 711)**

**Arabic:** خدمات الترجمة الفورية متوفرة لك مجاناً على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقتنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613 (TTY 711)**
- جميع الآخرين: **1-800-464-4000 (TTY 711)**

**Armenian:** Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal` **1-855-839-7613 (TTY 711)**
- Այլ` **1-800-464-4000 (TTY 711)**

**Chinese:** 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585 (TTY 711)**

**Farsi:** خدمات زبانی در 24 ساعت شبانهروز و 7 روز هفته بهصورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانهروز و 7 روز هفته (بهجز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613 (TTY 711)**
- سایر: **1-800-464-4000 (TTY 711)**

**Hindi:** बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-

स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं। सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY 711)
- बाकी दूसरे: **1-800-464-4000** (TTY 711)

**Hmong:** Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnuv twg, 7 hnuv tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnuv twg, 7 hnuv tuaj ib lim tiam twg (cov hnuv caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Dua lwm cov: **1-800-464-4000** (TTY 711)

**Japanese:** 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY 711)
- その他のご連絡先: **1-800-464-4000** (TTY 711)

**Khmer (Cambodian):** ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬដកស្រង់ ដែលបានបកប្រែ ជាភាសាខ្មែរ បទប្បញ្ញត្តិសង្គម និង ទៀត។ អ្នកក៏អាចស្នើសុំឱ្យបកប្រែឯកសារ និង ប្រព័ន្ធគ្រប់គ្រងសម្រាប់អ្នកពិការនៅទ្រព្យសម្បត្តិរបស់យើងផងដែរ។ ទូរសព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាក បទ)។

- Medi-Cal: **1-855-839-7613** (TTY 711)
- ផ្ញើសារទៅ: **1-800-464-4000** (TTY 711)

**Korean:** 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY 711)
- 기타 모든 경우: **1-800-464-4000** (TTY 711)

**Laotian:** ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜັດແປພາສາ ຫຼື ເອກະສານທີ່ ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ປິດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY 711)

**Mien:** Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnavg qiex zuqc longc mienh nzie weih nor douc waac lorx taux

ye mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY 711)

**Navajo:** Díí hózhó nízhońi bee hane' dóó jík'ah jóóni doonilwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádaáhágíí yádi nihookaa. Shí éí bee háidíinii bibee' haz'áanii dóó bee t'ah kodí bízikinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólqon'ígíí, 24 t'áadawohíí, 7 t'áadawohíigo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Yadilzingo bik'ehgo bee: **1-800-464-4000** (TTY 711)

**Punjabi:** ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY 711)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY 711)

**Russian:** Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия ТТТ 711)
- Все остальные: **1-800-464-4000** (линия ТТТ 711)

**Spanish:** Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY 711)

**Tagalog:** May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Lahat ng iba pa: **1-800-464-4000** (TTY 711)

**Thai:** มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY 711)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY 711)

**Ukrainian:** Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Усі інші: **1-800-464-4000** (TTY 711)

**Vietnamese:** Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị hỗ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY 711)
- Mọi chương trình khác: **1-800-464-4000** (TTY 711)