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 www.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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Not Applicable.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500 Individual / $3,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, health care this plan doesn’t cover, and services indicated in chart starting on page 2.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, but you may self-refer to certain specialists.</td>
<td>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.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay Plan Provider (You will pay the least)</th>
<th>What You Will Pay Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 / visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 / visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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) | No Charge | Not Covered | None |
|                    | Imaging (CT/PET scans, MRI's) | No Charge | Not Covered | None |

<table>
<thead>
<tr>
<th>If you need drugs to treat your illness or condition</th>
<th>Generic drugs (Tier 1)</th>
<th>Retail: $10 / prescription; Mail order: $20 / prescription</th>
<th>Not Covered</th>
<th>Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Retail: $25 / prescription; Mail order: $50 / prescription</td>
<td>Not Covered</td>
<td>Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 2)</td>
<td>Same as preferred brand drugs</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>20% coinsurance up to $150 / prescription</td>
<td>Not Covered</td>
<td>Up to a 30-day supply retail. Subject to formulary guidelines.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have outpatient surgery</th>
<th>Facility fee (e.g., ambulatory surgery center)</th>
<th>$25 / procedure</th>
<th>Not Covered</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at [www.kp.org/formulary](http://www.kp.org/formulary).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay Plan Provider (You will pay the least)</th>
<th>What You Will Pay Non-Plan Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 / visit</td>
<td>$100 / visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 / trip</td>
<td>$50 / trip</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 / visit</td>
<td>$25 / visit</td>
<td>Non-Plan providers covered when temporarily outside the service area.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Mental / Behavioral Health: $25 / individual visit. No Charge for other outpatient services; Substance Abuse: $25 / individual visit. $5 / day for other outpatient services</td>
<td>Not Covered</td>
<td>Mental / Behavioral Health: $12 / group visit; Substance Abuse: $5 / group visit.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Not covered</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay Plan Provider (You will pay the least)</td>
<td>What You Will Pay Non-Plan Provider (You will pay the most)</td>
<td>Limitations, Exceptions &amp; Other Important Information</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: No Charge; Outpatient: $25 / visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 / visit</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Up to 100 days maximum / benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not Covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Amounts in excess of $175 allowance</td>
<td>Not Covered</td>
<td>Allowance limited to once every 24 months.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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.)

- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care (30 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:

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

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, kwiiijigo 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**: $25
- **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)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $50
- The total Peg would pay is: $60

### 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**: $25
- **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)

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0
- The total Joe would pay is: $800

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

- **The plan’s overall deductible**: $0
- **Specialist copayment**: $25
- **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)

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0
- The total Mia would pay is: $310

The plan would be responsible for the other costs of these EXAMPLE covered services.
Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call 1-800-464-4000 (TTY 711).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your Evidence of Coverage or Certificate of Insurance or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at 1-800-464-4000 (TTY 711) 24 hours a day, 7 days a week (except closed holidays).

- **By mail:** Call us at 1-800-464-4000 (TTY 711) and ask to have a form sent to you.

- **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.

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

**Northern California**
Civil Rights/ADA Coordinator  
1800 Harrison St.  
16th Floor  
Oakland, CA 94612

**Southern California**
Civil Rights/ADA Coordinator  
393 East Walnut St.  
Pasadena, CA 91188

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 ocrportal.hhs.gov/ocr/portal/lobby.jsfor by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at hhs.gov/ocr/office/file/index.html.
Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los 7 días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al 1-800-788-0616 (TTY 711).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su Evidencia de Cobertura (Evidence of Coverage) o Certificado de Seguro (Certificate of Insurance), o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al 1-800-788-0616 (TTY 711) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** Llámenos al 1-800-788-0616 (TTY 711) y pída que se le envíe un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en kp.org/facilities [haga clic en "Español"] para obtener las direcciones).
- **En línea:** Use el formulario en línea en nuestro sitio web en en kp.org/espanol.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

**Northern California**

Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

**Southern California**

Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理障礙、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週 7 天每天 24 小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯服務，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電 1-800-757-7585（TTY711）。

訴訟指任何您或您的授權代表透過訴訟程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出訴訟。若需瞭解適用於自己的爭議解決選項，請參阅《承保範圍說明書》(Evidence of Coverage)或《保險證明書》(Certificate of Insurance)，或諮詢會員服務代表。

您可透過以下方式提出訴訟：

- 透過電話：請致電 1-800-757-7585（TTY 711）與會員服務部聯絡，服務時間為每週 7 天，每天 24 小時（節假日除外）。
- 透過郵件：請致電 1-800-757-7585（TTY 711）與我們聯絡並請我們將表格寄給您。
- 親自遞交：在計劃設施的會員服務辦事處填寫投訴或福利理索赔／申請表（請參閱 kp.org/facilities 上的保健業者名錄以查看地址）
- 線上：使用我們網站上的線上表格，網址為 kp.org

如果您在提交訴訟時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切訴訟都將通知 Kaiser Permanente 的民權事務協調員 (Civil Rights Coordinator)。您也可與 Kaiser Permanente 的民權事務協調員直接聯絡，地址：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
393 East Walnut St.,
Pasadena, CA 91188

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call 1-800-464-4000 and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Arabic: Kaiser Permanente تتوفر عليه مساعدات لغوية متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية.

Armenian: Kaiser Permanente հաջողություններն իրականացնում են 24 ժամ՝ 7 օր՝ աշխատանքային տեղամասների 除外.

Chinese: 吉林: 这是来自 Kaiser Permanente 的重要資訊。如果您需要協助了解此資訊，請致電 1-800-757-7585 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente و راهنمایی در 24 ساعت شبانه و 7 روز هفته، شامل روزهای تعطیل مورد است.

Hindi: यह Kaiser Permanente की ओर से महत्त्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया 1-800-464-4000 पर फोन करें और भाषा सहायता के लिए पूछें। सहायता कूटियों को छोड़कर, सतानाथ के साथ दिन, दिन के 24 घंटे, सरलता है।


Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、1-800-464-4000 に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。

Khmer: តំបោះឃើញការមិនព្យាយាមរបស់ Kaiser Permanente ដែលសំខាន់ៗនេះ នៅក្នុងវគ្គបណ្តុះបណ្តាលក្នុងការពេញនិយម 1-800-464-4000 មាមឈើយោងអំពីការពេញ

Korean: Kaiser Permanente에서 제공하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, 1-800-464-4000 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외).

Laotian: Kaiser Permanente, ຮູບບັນ ສໍາລັບການອັບດ້ວຍບັນຊີລະດຽວກັນ. ສະຫະລັບວັນ Việc 1-800-464-4000 ໃ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ້ໜ…...
Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al 1-800-788-0616 y pida ayuda lingüística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa 1-800-464-4000 at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras ng araw, 7 araw ng buwan, maliban sa mga araw na pista opisyal.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ กรุณาโทรศัพท์หมายเลข 1-800-464-4000 เพื่อขอความช่วยเหลือในภาษา สามารถโทรได้ตลอด 24 ชั่วโมงทุกวัน ยกเว้นวันหยุดเทศกาล.