


Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay For Covered Services

Coverage Period: 1/1/2019-12/31/2019

 KAISER PERMANENTE: WA PEBB - CDHP

Coverage for: Individual / Family | [Plan](#) Type: HDHP


All plans offered and underwritten by Kaiser Foundation Health [Plan](#) of the Northwest

 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 1-800-813-2000 (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 <http://www.healthcare.gov/sbc-glossary> or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible ?	\$1,400 Individual / \$2,800 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 policy, the overall family Deductible must be met before the Plan begins to pay.
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 ?	\$5,100 Individual / \$10,200 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 , the overall family Out-of-pocket Limit must be 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 ?	Yes. See www.kp.org or call 1-800-813-2000 (TTY: 711) for a list of participating providers .	This Plan uses a Provider Network . You will pay less if you use a Provider in the Plan's Network . You will pay the most if you use an out-of-Network Provider , and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing). Be aware your Network Provider might use an out-of-Network Provider for some services (such as lab work). Check with your Provider before you get services.

Do you need a Referral to see a Specialist ?	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 .
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 All [Copayment](#) and [Coinsurance](#) costs shown in this chart are after your [Deductible](#) has been met, if a [Deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care Provider office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not Covered	None
	Specialist visit	\$30 / 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)	X-ray: 15% Coinsurance Lab tests: 15% Coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	Not Covered	Some services may require prior authorization.
If you need drugs to treat your illness or condition More information about Prescription Drug Coverage is available at Formulary	Generic drugs	\$15 retail; \$30 mail order / prescription	Not Covered	Up to a 30-day supply retail or 90-day supply mail order. No charge for contraceptives. Subject to Formulary guidelines.
	Preferred brand drugs	\$40 retail; \$80 mail order / prescription	Not Covered	Up to a 30-day supply retail or 90-day supply mail order. No charge for contraceptives. Subject to Formulary guidelines.
	Non-preferred brand drugs	\$75 retail; \$150 mail order / prescription	Not Covered	Up to a 30-day supply retail or 90-day supply mail order. No charge for contraceptives. Subject to Formulary guidelines.
	Specialty Drug	50% Coinsurance up to \$150 retail	Not Covered	Up to a 30-day supply. KP Formulary applies. No charge for contraceptives. Subject to Formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	15% Coinsurance	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	15% Coinsurance		None
	Emergency Medical Transportation	15% Coinsurance		None
	Urgent Care	\$40 / visit	Not Covered	Non-participating providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	Not Covered	Prior authorization required.
	Physician/surgeon fees	15% Coinsurance	Not Covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: \$20 / visit Substance Abuse: \$20 / visit	Not Covered	Prior authorization required.
	Inpatient services	15% Coinsurance	Not Covered	Prior authorization required.
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	15% Coinsurance	Not Covered	Prior authorization required.
	Childbirth/delivery facility services	15% Coinsurance	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home Health Care	15% Coinsurance	Not Covered	130 day limit / year. Prior authorization required.
	Rehabilitation Services	Outpatient: \$30 / visit Inpatient: 15% Coinsurance	Not Covered	Outpatient: 60 visit limit / year. Prior authorization required. Inpatient: Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Select Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Habilitation services	Outpatient: \$30 / visit Inpatient: 15% Coinsurance	Not Covered	Outpatient: 60 visit limit / year. Prior authorization required. Inpatient: Prior authorization required.
	Skilled Nursing Care	15% Coinsurance	Not Covered	150 day limit / year. Prior authorization required.
	Durable medical equipment	10% Coinsurance	Not Covered	Subject to Formulary guidelines. Prior authorization required.
	Hospice Services	No charge	Not Covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	No charge / visit for refractive exam. Deductible does not apply.	Not Covered	Limited to 1 exam / year
	Children's glasses	No charge, Deductible does not apply.	Not Covered	Limited to select glasses or contacts every 12 months.
	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"> • Cosmetic surgery • Dental care (Adult & Child) • Infertility treatment 	<ul style="list-style-type: none"> • 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 (physician referred) • Bariatric surgery (Medically Necessary) • Chiropractic (12 visit limit / year) 	<ul style="list-style-type: none"> • Hearing aids (Adult - \$800 limit / ear, every 3 years) • 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 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	1-800-813-2000 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov .
Oregon Department of Insurance	1-888-877-4894 or www.dfr.oregon.gov
Washington Department of Insurance	1-800- 562- 6900 or www.insurance.wa.gov

Does this [Plan](#) provide [Minimum Essential Coverage](#)? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this [Plan](#) meet the [Minimum Value Standards](#)? Yes

If your [Plan](#) doesn't meet the [Minimum Value Standard](#), you may be eligible for a [Premium](#) to help you pay for a [Plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-813-2000 (TTY: 711).

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711).

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (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 overall Deductible	\$1,400
■ Specialist Copayment	\$30
■ Hospital (facility) Coinsurance	15%
■ Other (blood work) Coinsurance	15%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$40
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,800

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The Plan overall Deductible	\$1,400
■ Specialist Copayment	\$30
■ Hospital (facility) Coinsurance	15%
■ Other (blood work) Coinsurance	15%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$1,100
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The Plan overall Deductible	\$1,400
■ Specialist Copayment	\$30
■ Hospital (facility) Coinsurance	15%
■ Other (x-ray) Coinsurance	15%

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$200
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,640

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

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

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

Oregon	1-800-813-2000
Washington	1-800-813-2000
TTY	711

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 500 NE Multnomah St., Ste 100, Portland OR 97232, telephone number: 1-800-813-2000. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Help in your Language

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

አማርኛ (Amharic): የለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኤስሮ ፕሮሚት ኔይስ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ የለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውሎው ከስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تخطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإصدار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի միջոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրյալ է Ձեզ, որպեսզի գործադրություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, սպազանգանհարեք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bäsóò Wùdù (Bassa): O mò ni kpé bé m̀ ké gbo-kpá-kpá dyé dé ni miçùn niin bídí-wùdù mú pídyi. O jù ké m̀ dyi dyi-diè-dè bē bédé bá ni cèè-dè m̀ tò bó dè zò jè dyie ní, m̀w jù bá ni kùùn kpò jè dyi dyiin dé Kaiser Permanente múe ní, m̀w o dyi bí d̀ò jù bé m̀ ké dè d̀ò nyu bó wé jéé d̀ò kò ní, níí, d̀á nòbà bé wa tòà bó ni bóqòò m̀w ni gbèèò bíie, ké ni mu nyo-wuquún-zà-nyò d̀ò gbo wùdùùn.

বাংলা (Bengali): কিনা খরচ আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর সাহায্য পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো লাগিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পক্ষপাত গ্রহণ করার প্রয়োজনা হয়, তাহলে হাতখির সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে কল করুন।

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

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

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

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

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

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

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

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

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta ouwa rejyon ou a pou w ka pale ak yon entèprèt.

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

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

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

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asusu gi na akwughị ugwo o bula. O buru na i nwere ajuju gbasara akwukwo anamachoihe gi ma o bu mkpuchi si na Kaiser Permanente, ma o bu o buru na nke bu okwa a chorọ ka i mee ihe tupu otu ubochi, kpoọ nomba enyere maka steeti ma o bu mpaghara gi iji kwukorita okwu n'etiti onye okowa okwu.

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

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

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

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសាបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំ ឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិនបើគឺជាលិខិតជូនដំណឹងដែលតម្រូវឱ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີ່ທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມພາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majō! (Marshallese): Ewōr jimwe eo aṃ in bōk jipaṇ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjelā in ej aikuj bwe kwōn ṃakūtkūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷok nōṃba eo ej leḷok ñan state eo aṃ ak jikūṃ bwe kwōn marōñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áa ni nizaad bee níká i'doolwoł doo bik'és asíníááagóó éi bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yínikeedgo naaltsoos hadinilaa, éi bína'idítkid doogo, éi doodago díí naaltsoos haa'ida yoolkáalgo hait'áoda i'díilíif níníigo éi nitsaa hahoodzojí éi doodago t'áa aadi nahós'a'di ata' dahalne'ígúí bich'í' hólne'go bee bił ahił hodiłnih.

नेपाली (Nepali): तपाईंसग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्ने तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

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

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

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

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਆਰਾ ਦਿੱਤੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ.

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

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

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le tologi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoata'i i se faaliliu.

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

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

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

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

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

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کرنے کی ضرورت نہیں ہے۔ اگر آپ کے ذہن میں کوئی سوال یا درخواست ہے، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کیے گئے نمبر پر کال کریں۔

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

Yorùbá (Yoruba): O ní ètò láti rí irànlòwọ gbà nípá èdè rẹ láìsan owó. Bí o bá ní ibèèrè nípá iwé tí o kọ tàbí ìsedéédé nípàsẹ Kaiser Permanente, tàbí ifitònilétí yíí jẹ èyí o nilò láti igbèsẹ kan ní ojọ kan patọ, pé nọmbà tí a pèsè fún ipínlẹ tàbí agbègbè rẹ láti bá òngbifọ kan sọrọ.