This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.kp.org/kpic/ppo** or by calling **1-800-788-0710**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating provider: **$1,000** Individual/**$2,000** Family; Nonparticipating provider: **$2,000** Individual / **$4,000** Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Emergency Room Services: **$100** deductible. Inpatient Care: Participating provider: **$500**/ admission deductible. Nonparticipating provider: **$1,000**/admission deductible. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. Participating provider: **$2,500** Individual/**$5,000** Family; Nonparticipating provider: **$6,500** Individual/**$13,000** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, precertification penalties, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** See **www.kp.org/kpic/ppo** or visit **www.multiplan.com/kaiser** for a list of participating network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No.**	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 per visit	50% coinsurance per visit	Deductible waived.
	Specialist visit	$25 per visit	50% coinsurance per visit	Participating / Nonparticipating provider: Services related to infertility are covered at 30% / 50% coinsurance per visit, up to $1000 benefit maximum per calendar year.
	Other practitioner office visit	Not Covered	Not Covered	————————none————————
	Preventive care/ screening/ immunization	No Charge	50% coinsurance per visit	Deductible waived. Some preventive screenings (such as lab and imaging) may be at a different cost share. Participating provider: Routine Physical Exams are limited to one exam per calendar year. Nonparticipating provider: Routine Physical Exams are not covered.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance per test	50% coinsurance per test	——————none——————
	Imaging (CT/PET scans, MRIs)	30% coinsurance per test	50% coinsurance per test	Precertification required. Failure to precertify may result in a penalty up to $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.	Generic drugs	Plan pharmacy: $15 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Plan pharmacy: $15 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Prescriptions covered only when obtained from MedImpact Network Pharmacies. Prescription drugs do not apply to Medical Plan Deductible. Mail Order is available through Walgreen's Mail Service. Contraceptive Drugs are covered at no charge. Plan pharmacy: $30 per prescription for 31 to 60 day(s), $45 per prescription for 61 to 100 day(s).
	Preferred brand drugs	Plan pharmacy: $40 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Plan pharmacy: $40 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	$80 per prescription for 31 to 60 day(s), $120 per prescription for 61 to 100 day(s).
	Non-preferred brand drugs	Plan pharmacy: $40 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Plan pharmacy: $40 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	$80 per prescription for 31 to 60 day(s), $120 per prescription for 61 to 100 day(s).
	Specialty drugs	30% coinsurance per prescription	30% coinsurance per prescription	Self Injectable drugs covers up to 30 day supply retail. Not available through Mail Order. Insulin is covered at the Brand or Generic copay amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance per procedure after $100 deductible per procedures	50% coinsurance per procedure after $150 deductible per procedures	Nonparticipating provider: Outpatient surgery facility fees are limited to a maximum benefit of $600 per procedures. Precertification required. Failure to precertify may result in a penalty up to $500.
	Physician/surgeon fees	30% coinsurance per procedure	50% coinsurance per procedure	——————none——————
If you need immediate medical attention	Emergency room services	30% coinsurance per visit after $100 copay per visit	30% coinsurance per visit after $100 copay per visit	——————none——————
	Emergency medical transportation	50% coinsurance per trip	50% coinsurance per trip	——————none——————
	Urgent care	30% coinsurance per visit	50% coinsurance per visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance per admission after $500 deductible per admissions	50% coinsurance per admission after $1000 deductible per admissions	Precertification required. Failure to precertify may result in a penalty up to $500.
	Physician/surgeon fee	30% coinsurance per admission	50% coinsurance per admission	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 per visit	50% coinsurance per visit	Participating provider: Deductible waived.
	Mental/Behavioral health inpatient services	30% coinsurance per admission after $500 deductible per admissions	50% coinsurance per admission after $1000 deductible per admissions	Precertification required. Failure to precertify may result in a penalty up to $500.
	Substance use disorder outpatient services	$25 per visit	50% coinsurance per visit	Participating provider: Deductible waived.
	Substance use disorder inpatient services	30% coinsurance per admission after $500 deductible per admissions	50% coinsurance per admission after $1000 deductible per admissions	For detoxification only. Precertification required. Failure to precertify may result in a penalty up to $500.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance per visit	Participating provider: Deductible does not apply to Prenatal care Any non-routine obstetrical care is subject to the normal cost share.
	Delivery and all inpatient services	30% coinsurance per admission after $500 deductible per admissions	50% coinsurance per admission after $1000 deductible per admissions	Precertification required. Failure to precertify may result in a penalty up to $500.
If you need help recovering or have other special health needs	Home health care	20% coinsurance per visit	20% coinsurance per visit	Limited to 100 visits combined per calendar year. Private duty nursing not covered.
	Rehabilitation services	Inpatient: 30% coinsurance per admission after $500 deductible per admissions; Outpatient: 30% coinsurance per day	Inpatient: 50% coinsurance per admission after $1000 deductible per admissions; Outpatient: 50% coinsurance per day	Precertification required. Failure to precertify may result in a penalty up to $500. Limited to up to 60 days per calendar year combined for Physical, Speech & Occupational Therapy. Limits do not apply to services related to Severe Mental Illness or Serious Emotional Disturbance of a child.
	Habilitation services	30% coinsurance per visit	50% coinsurance per visit	Cost share applies to Outpatient services. Precertification required. Failure to precertify may result in a penalty up to $500. Participating provider: Deductible waived.
	Skilled nursing care	30% coinsurance per admission after $500 deductible per admissions	50% coinsurance per admission after $1000 deductible per admissions	Precertification required. Failure to precertify may result in a penalty up to $500.
	Durable medical equipment	30% coinsurance per item	50% coinsurance per item	Precertification required. Failure to precertify may result in a penalty up to $500. Certain items limited to a benefit maximum of $2000 combined per calendar year. Requires prior authorization.
	Hospice service	30% coinsurance per service	50% coinsurance per service	Precertification required. Failure to precertify may result in a penalty up to $500. Combined maximum benefit while insured of 180 days per lifetime.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Nonparticipating Provider	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

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

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless medically necessary
- Weight loss programs

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

- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-788-0710. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Dell Health Services by calling at 1-800-392-8649.

You may also contact the California Department of Insurance at 1-800-927-4357 (1-800-927-HELP) or you may write to the California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013. Or go to the California Department of Insurance website at www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0710 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-788-0710 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710 or TTY/TDD 1-800-777-1370

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

The PPO Plan is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP).

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,220
- **Patient pays** $3,320

Sample care costs:

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

Patient Pays:

Deductibles	$1,200
Copays	$20
Coinsurance	$1,900
Limits or exclusions	$200
Total	**$3,320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,220
- **Patient pays** $2,180

Sample care costs:

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

Patient Pays:

Deductibles	$1,000
Copays	$800
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,180**

Note: The coverage example was calculated assuming that the member used KP providers for all services, drugs, and DME.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

KAISER PERMANENTE®

Kaiser Permanente Insurance Company
Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-464-4000. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-464-4000 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

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No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-464-4000. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Doo Bą́ą́h Íliníígóó Saad Bee Áká'e'eyeed. Ata' halne'é ła' ná chóidoot'eeł dóó naaltsoos t'áá ni nizaad k'ehjí nich'į' yídóołtah. Shíká a'doowoł nínízingo, naaltsoos bee nééhózinígíí bikáa'gi béésh bee hane'é biká'ígíí bik'ehgo nihich'į' hodíilnih doodaii 1-800-464-4000jį' hodíilnih. T'áá náásgóó shíká' a'náá'doowoł nínízingo éí CA Béeso Ách'ą́ą́h Naa'nil Bił Haz'ą́ąjį' 1-800-927-4357jį' béésh bee hodíilnih. Navajo

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-464-4000. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-800-464-4000 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-464-4000. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-464-4000 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-464-4000. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-464-4000 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-800-464-4000 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-464-4000 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-464-4000 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-464-4000. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-464-4000. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

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