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, www.kp.org/plandocuments or call 1-800-788-0710 (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 1-800-788-0710 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating Provider Tier: $6,300 Individual / $12,600 Family; Non-Participating Provider Tier: $12,600 Individual / $25,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Participating Pharmacy: $500 Individual / $1,000 Family. 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.
What is the out-of-pocket limit for this plan?	Participating Provider Tier: $8,200 Individual / $16,400 Family; Non-Participating Provider Tier: $16,400 Individual / $32,800 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, precertification penalties, balance billing charges, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org/kpic/ppo or call 1-800-788-0710 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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: Participating Provider Tier (You will pay the least)	What You Will Pay: Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$65 / visit	100% coinsurance	Participating Provider: Deductible waived for the first three non-preventive primary care, specialty care, urgent care. Non-Participating Provider: Up to out-of-pocket limit
	Specialist visit	$95 / visit	100% coinsurance	Participating Provider: Deductible waived for the first three non-preventive primary care, specialty care, urgent care. Non-Participating Provider: Up to out-of-pocket limit.
	Preventive care/screening/ Immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	Routine physical exams are not covered for Non-Participating Provider. 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: 40% coinsurance Lab tests: $40 / test, deductible does not apply	100% coinsurance	Non-Participating Provider: X-ray: Up to out-of-pocket limit. Lab test :Up to out-of-pocket limit
	Imaging (CT/PET scans, MRIs)	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required. Failure to precertify may result in a penalty of up to $500.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/kpic/ppo	Generic drugs	MedImpact: $18 / prescription (retail). $36 / prescription (mail order). After drug deductible.	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Preferred brand drugs	MedImpact: 40% coinsurance up to $500 / prescription. After drug deductible.	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Non-preferred brand drugs	MedImpact: 40% coinsurance up to $500 / prescription. After drug deductible.	Not covered	Up to a 30-day supply retail or 100-day supply mail order (Walgreens' home delivery). Subject to formulary guidelines. No charge for contraceptives.
	Specialty drugs	MedImpact: 40% coinsurance up to $500 / prescription. After drug deductible.	Not covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required. Failure to precertify may result in a penalty of up to $500.
	Physician/surgeon fees	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required. Failure to precertify may result in a penalty of up to $500.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Coinsurance waived if admitted to hospital as inpatient.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.
	Urgent care	$65 / visit	100% coinsurance	Participating Provider: Deductible waived for the first three non-preventive primary care, specialty care, urgent care.Non-Participating Provider: Up to out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required (does not apply to emergency admissions, and admissions for delivery of a child). Failure to precertify may result in a penalty of up to $500.
	Physician/surgeon fees	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required (does not apply to emergency admissions and services, and admissions and services for delivery of a child). Failure to precertify may result in a penalty of up to $500.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$65 / individual visit; No charge for other outpatient services	100% coinsurance	Participating Provider: $32 / group visit; Non-Participating Provider: Up to out-of-pocket limit.
	Inpatient services	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Precertification required (does not apply to emergency admissions and services). Failure to precertify may result in a penalty of up to $500.
If you are pregnant	Office visits	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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 (e.g. ultrasound.)
	Childbirth/delivery professional services	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.
	Childbirth/delivery facility services	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider Tier (You will pay the least)	Non-Participating Provider Tier (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Up to 100 visits combined / year (Limit does not apply to physical, occupational, and speech therapy visits). Precertification required. Failure to precertify may result in a penalty of up to $500.
	Rehabilitation services	Outpatient: $65 / visit, deductible does not apply; Inpatient: 40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit.
	Habilitation services	Outpatient: $65 / visit, deductible does not apply; Inpatient: 40% coinsurance	100% coinsurance	Precertification required. Failure to precertify may result in a penalty of up to $500. Non-Participating Provider: Up to out-of-pocket limit.
	Skilled nursing care	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Up to 100 days / benefit period. Precertification required. Precertification required. Failure to precertify may result in a penalty of up to $500.
	Durable medical equipment	40% coinsurance	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Up to $2,000 limit / year for certain items. Precertification required. Failure to precertify may result in a penalty of up to $500.
	Hospice services	No charge, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge	Limited to 1 exam / year
	Children's glasses	No charge, deductible does not apply	100% coinsurance	Non-Participating Provider: Up to out-of-pocket limit. Limited to 1 pair of select frames and lenses / year.
	Children's dental check-up	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 2 check-ups / year

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Infertility treatment ($1,000 limit / year)	• Routine eye care (Adult)
• Bariatric surgery		

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

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

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

Kaiser Permanente Member Services	1-800-788-0710 (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
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet 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 1-800-788-0710 (TTY: 711)

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-0710 (TTY: 711).

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-788-0710 (TTY: 711)

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-0710 (TTY: 711)

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

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

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	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$40

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:	
Cost Sharing	
Deductibles	$6300
Copayments	$0
Coinsurance	$1300
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$7650**

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

The plan's overall deductible	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$40

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:	
Cost Sharing	
Deductibles	$1900
Copayments	$300
Coinsurance	$1200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3400**

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

The plan's overall deductible	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$40

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:	
Cost Sharing	
Deductibles	$2800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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. TTY users call 711. English

Servicios en otros idiomas sin ningún costo. Puede conseguir un intérprete. Puede conseguir que le lean los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-464-4000. Para obtener más ayuda, llame al Departamento de Seguro de CA al 1-800-927-4357. Los usuarios de la línea TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員。您可請人將文件唸給您聽，且您可請我們將您語言版本的部分文件寄給您。如需協助，請致電列於會員卡上的電話號碼或致電 1-800-464-4000 與我們聯絡。如需進一步協助，請致電 1-800-927-4357 與加州保險局聯絡。聽障及語障電話專線使用者請致電 711。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. TTY users call 711. English

Doo bik'é azláágoo Saad Bee Áká Aná'álwo'. Ata' halne'í ná shóidoot'eeł. Nizaad bee naaltsoos nich'į' yídóoltah Shíká i'doolwoł nínízingo éí béésh bee hodíílnih, naaltsoos bee nééhózinígíí bik'ehgo hane'í bikáá' éí doodago kojį' hodíílnih 1-800-464-4000. Náánáá łahgo ałdó' shíká i'doolwoł nínízingo kojį' hodíílnih CA Dept. of Insurance bik'ehgo hane'í éí 1-800-927-4357. TTY chodayooł'ígíí éí díí 711. Navajo

Dịch vụ về ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và được người đọc giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Để được giúp đỡ, xin gọi chúng tôi theo số điệnthoại ghi trên thẻ ID hội viên hoặc số 1-800-464-4000. Để được giúp đỡ thêm, vui lòng gọi Bộ Bảo hiểm CA theo số 1-800-927-4357. Người sử dụng TTY gọi số 711. Vietnamese

무료 언어 서비스. 한국어 통역 서비스 및 한국어로 서류를 낭독해 드리는 서비스를 제공하고 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와 있는 전화번호 또는 1-800-464-4000 번으로 문의하십시오. 보다 자세한 사항은 캘리포니아 주 보험국, 전화번호 1-800-927-4357 번으로 문의하십시오. TTY 사용자 번호 711. Korean

Mga Libreng Serbisyo kaugnay sa Wika. Maaari kayong kumuha ng tagasalin-wika at hingin na basahin sa inyo ang mga dokumento sa sarili ninyong wika. Para humingi ng tulong, tawagan kami sa numerong nakasulat sa inyong ID card o sa 1-800-464-4000. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Dapat tumawag ang mga gumagamit ng TTY sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք օգտվել բանավոր թարգմանչի ծառայություններից և խնդրել, որ փաստաթղթերը Ձեր լեզվով կարդան Ձեզ համար:Օգնության համար զանգահարեք մեզ՝ Ձեր ID քարտի վրա նշված կամ 1-800-464-4000 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայիապահովագրության դեպարտամենտ՝ 1-800-927-4357 հեռախոսահամարով: TTY -ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги языкового перевода. Вы можете воспользоваться услугами переводчика, при этом документы могут быть зачитаны Вам на Вашем языке. Чтобы получить помощь, позвоните нам по телефону, указанному в Вашей идентификационной карточке участника, или 1-800-464-4000. За дополнительной помощью обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357. Пользователи TTY, звоните по номеру 711. Russian

無料の言語サービス。通訳に依頼して、日本語で書類を読んでもらうことができます。通訳サービスが必要な際は、ID カードに記載の番号、または 1-800-464-4000 にお電話ください。さらにヘルプが必要な場合は、カリフォルニア州保険庁（1-800-927-4357）にお電話ください。TTY ユーザーの方は、711 にお電話ください。Japanese

خدمات زبان به صورت رایگان. می توانید از خدمات مترجم شفاهی بهره مند شوید و ترتیب خواندن متن ها برای شما به زبان خودتان را بدهید. برای دریافت کمک و راهنمایی، با ما به شماره ای که روی کارت شناسایی شما قید شده یا 1-800-464-4000تماس بگیرید. برای دریافت کمک و راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY با شماره 711 تماس حاصل نمایند. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-464-4000 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ, ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែបាន និងឲ្យគេអានឯកសារជូនអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើងតាមលេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក ឬ 1-800-464-4000។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ អ្នកប្រើ TTY ហៅលេខ 711។ 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 مزيد من المعلومات اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. لمستخدمي خدمة الهاتف النصي يرجى الاتصال على 711.Arabic

Cov Kev Pab Txhais Lus Tsis Raug Nqi Dab Tsi Koj muaj tau ib tug neeg txhais lus thiabhais tau kom nyeem cov ntaub ntawv ua koj hom lus rau koj. Xav tau kev pab, hu rau peb ntawm tus xov toojteev muaj nyob rau ntawm koj daim yuaj ID los yog 1-800-464-4000. Xav tau kev pab ntxiv hu rau CA Tuam Tsev Tswj Kev Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

मुफ्त भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और आपको दस्तावेज़ आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-464-4000 पर हमें फोन करें। अधिक सहायता के लिए कैलीफ़ोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर फोन करें। TTY प्रयोक्ता 711 पर फोन करें। Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอรับบริการล่ามแปลภาษาและขอให้อ่านเอกสารให้คุณฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อหาเราตามหมายเลขที่ระบุอยู่บนบัตร ID ของคุณหรือหมายเลข 1-800-464-4000 หากต้องการความช่วยเหลือในเรื่องอื่นๆ เพิ่มเติม โปรดโทรติดต่อฝ่ายประกันโรคมะเร็งที่หมายเลข 1-800-927-4357 ผู้ใช้ TTY โปรดโทรไปที่หมายเลข 711. Thai