Welcome to Kaiser Permanente

PPO Resource Guide
Colorado

coloradolevelfunded.kp.org

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

Your Preferred Provider Organization (PPO) Plan

Welcome! In this guidebook, you'll find details about your PPO Plan, instructions on how to choose a doctor and fill your prescriptions, get care, and important resources.

1 Understand your plan › **2** Transfer prescriptions › **3** Get Care

We're here to help

You can reach Customer Service at **1-800-401-8405** (TTY **711**), Monday through Friday, from 5 a.m. to 7 p.m.

1 Understand your plan

How the Preferred Provider Organization (PPO) Plan works

Your PPO plan works the way you want it to. You can choose your own provider under either tier and you can move between tiers at any time.

This resource guide provides an overview of your plan. Details of your plan can be found in your employer's plan Summary Plan Description (SPD). If there are differences between this document and your SPD, your SPD will prevail.

The benefits provided under the participating and non-participating tiers are not the same.

Kaiser Permanente is contracted with First Health®* when you get care in Colorado and other Kaiser Permanente states (CA, GA, HI, MD, VA, OR, WA or the District of Columbia). Kaiser Permanente is also contracted with the Cigna PPO Network.** The Cigna PPO Network only provides access to care in non-Kaiser Permanente states.

	Participating Provider Tier	Non-Participating Provider Tier
Provider Choice	First Health, in Kaiser Permanente states, Cigna PPO Network only in non-Kaiser Permanente states, & OptumRx Contracted Pharmacies	Any Licensed Provider & Any Pharmacy
Out-of-Pocket Cost	Lower Cost Some services are subject to a deductible, and then coinsurance	Higher Cost Most services are subject to a deductible and then coinsurance
Claims	Provider generally completes and submits claims forms You will not be balance billed	You will generally complete and submit claim forms You can be balance billed if your provider bills you for more than your plan allows

For questions about your plan

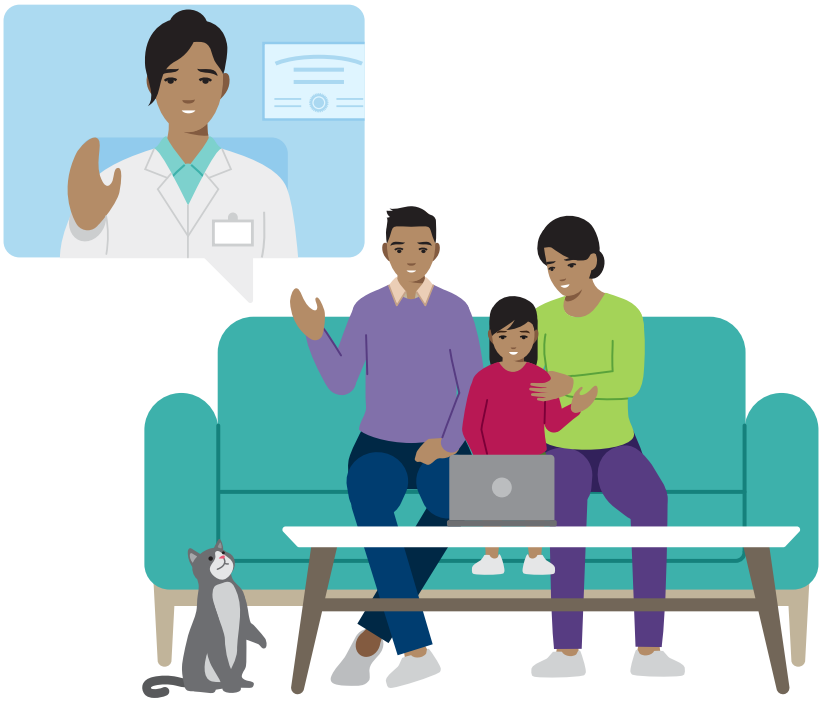
Please call Customer Service at **1-800-401-8405** (TTY **711**), Monday through Friday, from 5 a.m. to 7 p.m.

*Kaiser Permanente is contracted with First Health®. First Health is a brand name of First Health Group Corp.
**The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO for Shared Administration. Cigna is an independent company and not affiliated with Kaiser Permanente Insurance Company. Access to the Cigna PPO Network is available through Cigna's contractual relationship with Kaiser Foundation Health Plan, Inc. and your Plan's Administrative Services Only (ASO) Agreement with Kaiser Permanente Insurance Company (KPIC). The Cigna PPO Network is provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Choose your doctor—and change anytime

Your PPO plan gives you the freedom to choose how you receive care. When you go to your appointments, please make sure you bring your ID card. If your provider has questions about your plan, you can refer them to the Customer Service phone number on the front of your ID card.

Participating Provider Tier	**Choosing a Participating Provider** First Health providers and hospitals are in Colorado and other Kaiser Permanente states (CA, GA, HI, MD, OR, VA, WA and the District of Columbia). Cigna PPO Network providers and hospitals are only available outside Kaiser Permanente states. For assistance finding a participating provider, visit **coloradolevelfunded.kp.org** or call **1-800-401-8405** (TTY **711**).
Non-Participating Provider Tier	**Choosing a provider in the community** If you seek care in the Non-Participating Provider Tier, you can work directly with any licensed provider or facility anywhere. You may pay more if you choose to see a non-participating provider. You can call the provider's office and make an appointment. Simply state that your plan allows you to see any provider in the community.



2 Transfer or fill your prescriptions

You can fill prescriptions from any provider at any pharmacy using one of these pharmacy options.

Participating Provider Tier	Fill prescriptions at participating OptumRx pharmacies. • To verify if a specific pharmacy participates, or to obtain a complete list of participating pharmacies, call OptumRx at **1-866-427-7701** (TTY **711**), 24 hours a day. For a list of covered drugs, visit **kp.org/formulary**, choose your region, and select the "Colorado Level-Funded PPO/POS formulary" link.
Non-Participating Provider Tier	To transfer a prescription to a non-participating pharmacy, you will need to contact the pharmacy directly. • Mail Order is not available under this pharmacy option. • You may need to pay full costs and submit claims to OptumRx for reimbursement subject to the terms and conditions of your plan. Claim forms can be found at **coloradolevelfunded.kp.org.** Please have the following information ready when you call: • The name and strength of the medication • The prescription number of the prescribed medication • The name and phone number of the transferring pharmacy For a list of covered drugs, visit **kp.org/formulary**, choose your region, and select the "Colorado Level-Funded PPO/POS formulary" link.

Prior Authorization of Outpatient Prescription Drugs

With your PPO plan, we use a drug formulary. In addition, certain outpatient prescription drugs may be subject to utilization management requirements, such as prior authorization, step therapy, and/or quantity limits. Please ask your prescribing provider to complete and submit a KPIC Prior Authorization Request in writing when applicable. There is also a Provider Pharmacy Authorization phone number on your ID card to assist your provider. If you have questions about your pharmacy benefits, please call OptumRx Pharmacy Benefits at **1-866-427-7701**.

3 Get care

Prior Approval (pre-certification)

To ensure that the medical service ordered is medically necessary, prior approval may be required. This is known as pre-certification for services ordered by a participating or non-participating provider.

Participating Provider Tier	Pre-certification is required for all inpatient care (such as hospital surgical procedures) and certain outpatient procedures. Your Participating Provider is required to obtain pre-certification at least three days before you receive certain services or have any inpatient hospital stays, or within 24 hours of an emergency department admission. Some examples of services requiring pre-certification include: • Inpatient hospital stay • Outpatient surgery • Home health, hospice, and skilled nursing facility care • Imaging For First Health Network providers, contact Permanente Advantage at **1-888-525-1553** (TTY **711**) , Monday through Friday, 8 a.m. to 5 p.m., to initiate pre-certification. Cigna PPO Network providers will manage any necessary pre-certification.
Non-Participating Provider Tier	Pre-certification is required for all inpatient care (such as hospital surgical procedures) and certain outpatient procedures. You are required to obtain pre-certification at least three days before you receive certain services or have any inpatient hospital stays, or within 24 hours of an emergency department admission. Your physician, hospital, or authorized representative may obtain pre-certification on your behalf. Some examples of services requiring pre-certification include: • Inpatient hospital stay • Outpatient surgery • Home health, hospice, and skilled nursing facility care • Imaging You may request pre-certification by calling Permanente Advantage at 1-**888-525-1553** (TTY **711**), Monday through Friday, 8 a.m. to 5 p.m. If you do not obtain pre-certification for covered services that require it, you may pay a penalty or services may not be covered at all.

Seeing your doctor

See your doctor for preventive screenings, new or existing health concerns, or a change in a health condition that is not an urgent need.

Participating Provider Tier	Provider networks change regularly. Before making your appointment, confirm that the provider is still participating in the network. See page 4 for how to do this. When you see a participating provider for the first time, let the office staff know you are using the Participating Provider Tier of your plan, which allows you to see participating providers who are part of the network. For assistance finding a participating provider, visit **coloradolevelfunded.kp.org** or call **1-800-401-8405** (TTY **711**).
Non-Participating Provider Tier	If you see a non-participating provider for care, speak with your non-participating provider for information on making appointments and to learn about how his/her care team is structured. When you see a non-participating provider for the first time, let the office staff know you are using the Non-Participating Provider Tier of your plan, which lets you see any licensed provider.

Medical Advice

Whenever you need medical advice or are unsure whether you need urgent care, call your participating or non-participating provider, who can direct your care.

Care for Newborns

Your newborn will receive care from the time of birth through the first 31 days. Eligibility for care is available according to your employer's plan and coordination of benefits may apply. For information on enrolling your newborn for health care beyond 31 days, call **1-800-401-8405** (TTY **711**).

Hospital Care

Participating Provider Tier	• You can receive inpatient and outpatient services from the participating provider network. • See page 6 for any pre-certification requirements.
Non-Participating Provider Tier	• You can receive inpatient and outpatient services from any licensed or accredited hospitals/facilities and providers. • See page 6 for any pre-certification requirements. • You may be responsible for a higher out-of-pocket expense if you receive care from a non-participating provider or facility. • The provider/facility may require you to pay upfront for these services. If that should occur then you will also need to submit a reimbursement form for each provider or facility. See claims section on page 11 for more information.

Emergency Care

When your health is in danger and you require immediate care. For example, if you feel like you are having a heart attack, have severe difficulty breathing, lose the ability to talk or to move one side of your body, develop slurred speech, experience a sudden change in consciousness, have serious wounds or injuries, or have a psychiatric emergency.

If you think you are experiencing an emergency medical condition, call **911**, or if time and safety permit, go to the nearest emergency room. Your care will be covered. For a complete definition of an emergency medical condition, please refer to **kp.org**.

Contact Permanente Advantage as soon as possible after an emergency department admission. See page 6 for any pre-certification requirements.

Emergency care is covered at the Participating Provider Tier benefit level, and you will be responsible only for the Participating Provider Tier copay or coinsurance, regardless of where you seek care.

Urgent Care

For illnesses or injuries requiring prompt attention but that are not medical or psychiatric emergencies. This can include abdominal pain, asthma, cough, fever, sore throat, earaches, headaches, migraines, minor lacerations, ankle sprains, and other urgent conditions.

Participating Provider Tier	• If you think you need urgent care, call your participating provider who can direct your care. • You have access to urgent care facilities that are part of the participating provider network anywhere in the country. • Before seeking urgent care, you should confirm that the facility is part of the participating provider network.
Non-Participating Provider Tier	• If you think you need urgent care, call your non-participating provider who can direct your care. • You have access to any urgent care facility not already in the Participating Provider Tier, anywhere in the country. • The facility may ask you to pay in full when you receive care. If so, retain a copy of the bill as proof of payment, and submit your claim for reimbursement.

X-Ray and Imaging Services

Participating Provider Tier	• Before scheduling any X-rays or other imaging services, check first to be sure the facilities are part of the participating provider network. • Pre-certification may be required. Refer to your Summary Plan Description. • For more information on pre-certification, see page 6.
Non-Participating Provider Tier	• You can receive X-rays and other imaging services at any facility. • Pre-certification may be required. Refer to your Summary Plan Description. For more information on pre-certification, see page 6. • If you receive tests and screenings in non-participating facilities, you will likely pay in full and submit a claim for reimbursement subject to the terms and conditions of your plan. The provider may also bill you for the difference, if any, between actual billed charges and the maximum allowable charge (as determined by KPIC). Refer to your Summary Plan Description for more details.

Lab Tests and Results

Participating Provider Tier	Before scheduling any lab test, check first to be sure the facilities are part of the participating provider network.
Non-Participating Provider Tier	• You can receive lab services at any facility. • If you receive tests and screenings at non-participating facilities, you will likely pay in full and submit a claim for reimbursement subject to the terms and conditions of your plan. The provider may also bill you for the difference, if any, between actual billed charges and the maximum allowable charge (as determined by KPIC). Refer to your Summary Plan Description for more details.

Behavioral/Mental Health

Participating Provider Tier	You can receive outpatient care for mental illness, emotional disorders, and drug or alcohol abuse from a provider in the network without a referral. For assistance with finding a participating provider, call Customer Service at **1-800-401-8405** (TYY **711**), Monday through Friday, 5 a.m. to 7 p.m., or visit **coloradolevelfunded.kp.org**. Pre-certification is required before receiving inpatient hospital care. Depending on your plan, it may also be required for certain outpatient procedures. See page 6 for more information about pre-certification.
Non-Participating Provider Tier	You can receive outpatient care from any licensed behavioral health or chemical dependency professional for mental illness, emotional disorders, and drug or alcohol abuse. Pre-certification is required before receiving inpatient hospital care. Depending on your plan, it may also be required for certain outpatient procedures. See page 6 for more information about pre-certification.

Claims

Generally speaking, when you have care under the Participating Provider Tier, you will not have to file a claim. That is handled by your provider. You may be required to pay the full amount you are charged when you receive care from a non-participating provider. If you are asked to pay out-of-pocket, you must submit three items to be reimbursed.

1. Completed claim form

- Name of the patient
- Patient's ID number (on each page of the document)
- Date of service

2. Itemized bill from your provider (please contact your provider and request the itemized bill)

- Services provided (procedures performed, with CPT codes)
- Diagnosis with ICD code
- Amount charged for each service

3. Proof of payment (one of the following)

- Credit card receipt
- Bank statement
- Copies of your original check (front and back)

To obtain medical claim forms, go to **coloradolevelfunded.kp.org** or call Customer Service at **1-800-401-8405** (TTY **711**).

Timelines for filing a claim

Participating Provider Tier	• Provider generally completes and submits claim forms. • If you do have to pay for services out-of-pocket, you have up to 12 months from the date you received care to submit your claim.
Non-Participating Provider Tier	• Your non-participating provider does not have a contracted rate and can establish their own fee. • You will be responsible for the balance if your provider bills you for more than your plan allows. • You have up to 12 months from the date you received care to submit your claim.

Where to send your claim

Mail your claim form and itemized statement to:
KPIC Self-Funded Claims Administrator
P.O. Box 30547
Salt Lake City, UT, 84130-0547
Payor ID: 94320

What to expect next

You'll receive a response within 30 days. If your claim form is submitted incomplete or is missing information or documentation or unsigned it will be returned for correction and re-submission.

If the claim submitted is complete you will receive an Explanation of Benefits (EOB) that will show you a breakdown of the charges and payments for your visit and will also show how much you are responsible for paying, as well as your deductible and out-of-pocket maximum.

If your claim is denied

If your claim is denied, in whole or in part, you will receive detailed written information on the EOB document you receive. You have the right to file an appeal if you disagree with the decision not to authorize medical services or drugs, or not to pay for a claim. Read your Summary Plan Description (SPD) for more information.

Getting care away from home

You are covered to receive care for emergency illness or injury anywhere in the world, regardless of provider. Use this checklist before you get care away from home. A little planning makes a big difference. Plan now for a healthy trip.

- ☐ Contact your doctor if you need to manage a condition during your trip.
- ☐ Refill your prescriptions to have enough while you're away.
- ☐ Make sure your immunizations are up to date, including your yearly flu shot.
- ☐ Bring your health insurance ID card. It has important phone numbers on the back.

For additional information, please call Customer Service at **1-800-401-8405** (TTY **711**).

Glossary

Preventive care

With most plans, preventive care is at no additional cost to you when you access a provider in the Participating Provider Tier. If you receive preventive care services through a non-participating provider you may have to pay the full cost of services and submit a claim for reimbursement. Additionally, a copayment, deductible, and/or coinsurance may apply.

Preventive care includes routine physicals, well-child visits, and certain screenings and tests (such as mammograms). So there's no need to delay making your first appointment with your doctor.

Sometimes, the doctor will want to do something that is not preventive care. For example, during your routine appointment, the doctor may find a mole that needs to be removed for testing. Because that's not covered as preventive care, you will be asked to pay a copayment, deductible, or coinsurance for the service. In most cases, you will get a bill in the mail for such additional, nonpreventive services.

Types of Cost Share

Here are different types of costs (such as copays, coinsurance, or deductibles) you may be required to pay under your plan.

Copayments (copays)

The specific dollar amount you pay for a covered service (e.g., nonpreventive office visit) every time that service is provided. Copayments vary depending on your plan and count toward your annual out-of-pocket maximum for most services.

Coinsurance

The percentage of charges you pay for a covered service. For example, if your coinsurance is 15 percent and your allowed office visit cost is $100, then you pay $15 and the health plan pays $85. Services are often subject to a deductible. Coinsurance varies according to your plan. Coinsurance payments also count toward your annual out-of-pocket maximum for most services.

Nearly all plans have copayments or coinsurance. A copayment or coinsurance may be owed on the day you receive services, for each visit, even if multiple visits occur on the same day.

Out-of-pocket maximum

The maximum amount you pay out of pocket each plan year for most covered services. Once you meet your out-of-pocket maximum, you won't pay anything for most covered services for the remainder of the plan year. For a detailed description, including any cross accumulation of your out-of-pocket maximum between tiers, see your Summary Plan Description. Fees, penalties, or balance billing won't count toward your out-of-pocket maximum.

Deductible

The set amount you must pay each plan year for covered medical services before the health plan begins to pay its share. Not all services may be subject to the deductible. Deductibles vary depending on the plan you have.

Once you have met your deductible, you will be required to pay only the applicable copayment or coinsurance for most covered services for the remainder of your plan year until you reach your out-of-pocket maximum. Certain conditions may apply.

If you have a deductible, you will be billed for the full allowed amount for each service that is subject to the deductible during check-in or after the service via mailed bill. You may also receive an estimate of your charges before your office visit for certain services, and you may choose to make a deposit payment based on that estimate.

Balance Billing

This may occur when you are billed for any charges above the maximum allowable charge set out in your Summary Plan Description. There is no balance billing in the Participating Provider Tier. **You may be balance billed for services received at the Non-Participating Provider Tier**.

Maximum Allowable Charge

For providers in the Participating Provider Tier, the maximum allowable charge is the negotiated contracted rate agreed upon to provide discounts for covered services.

For all other providers, it is the lesser of the usual, customary, and reasonable (UCR) charges and the actual billed charges.

When you go to a provider or facility or receive services in the Non-Participating Provider Tier, you may be balance billed for any amount in excess of the maximum allowable charge. It is important that you understand that you are responsible for 100% of all amounts balance billed, and that payments of a balance bill do not count towards your deductible or out-of-pocket maximum.

Usual, Customary, and Reasonable (UCR)

The general level of charges made by other providers for specified covered services within the area where the charge is incurred.

Important Contacts

Participating Provider Tier	**See your primary care or specialty physician** Call your participating provider directly. For assistance finding a participating provider, visit **coloradolevelfunded.kp.org** or call Customer Service at **1-800-401-8405** (TTY **711**). **Urgent Care** Visit **coloradolevelfunded.kp.org** for a list of urgent care facilities participating in the network, or call Customer Service at **1-800-401-8405** (TTY **711**). **Emergency Care** Emergency care is covered at the participating provider benefit level regardless of the participating status of the provider.
Non-Participating Provider Tier	**See your primary care or specialty physician** Call your Non-Participating Provider directly. **Urgent Care** You can visit any licensed out-of-network urgent care facility. Make sure to keep a copy of your bill to submit with your claim for reimbursement. **Emergency Care** Emergency care is covered at the Participating Provider benefit level regardless of the participating status of the provider.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC 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: **1-866-213-3062** (TTY: **711**)

If you believe that KPIC 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 by mail or phone at: KPIC Civil Rights Coordinator, 3701 Boardman-Canfield Rd, Canfield OH 44406, telephone number 1-866-213-3062.

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-866-213-3062** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-866-213-3062** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-213-3062** (TTY: **711**).

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-866-213-3062** (TTY՝ **711**):

Ɓǎsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-866-213-3062** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-866-213-3062** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-866-213-3062**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-866-213-3062** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-213-3062** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-866-213-3062** (TTY: **711**).

ગુજરાતી (Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-866-213-3062** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-213-3062** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-866-213-3062** (TTY: **711**) पर कॉल करें।

Hmoob (Hmong): CEEB TOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, uas pab dawb rau koj. Hu rau **1-866-213-3062** (TTY: 711).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-866-213-3062** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-866-213-3062** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-866-213-3062**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-866-213-3062** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-213-3062** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-866-213-3062** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-866-213-3062** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-866-213-3062** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-866-213-3062** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-213-3062** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-866-213-3062** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-866-213-3062** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-866-213-3062** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-213-3062** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-866-213-3062** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-866-213-3062** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-866-213-3062** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-866-213-3062** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-213-3062** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-866-213-3062** (TTY: **711**).

Your guide to better health

Keep this book handy as a quick reference to getting the most out of your plan.

Please call the the numbers below for assistance:

Customer Service Center
1-800-401-8405 (TTY **711**)

Pharmacy Benefits
OptumRx: **1-866-427-7701**

Appointments, Urgent Care and Medical Advice
1-866-311-4464 (TTY **711**)

To find providers and locations, visit **kp.org/locations**.

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