



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, call **1-855-270-2327** or visit us at [lacare.org](http://lacare.org). 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call **1-855-270-2327**.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,400 individual / \$2,800 family.</b> Per calendar year	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> Family, physician, and specialist office visits, <a href="#">preventive care</a> , and other services not subject to <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive</a> without cost sharing and before you meet your deductible. See a list of covered <a href="#">preventive</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>Yes. \$100 individual / \$200 family</b> for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$2,850 individual / \$5,700 family.</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See lacare. <a href="http://lacare.org">lacare.org</a> or call 1-855-270-2327 (TTY 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a participating <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use a <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>Yes.</b>	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a>



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$15 / visit	Not covered	None
	<u>Specialist</u> visit	\$25 / visit	Not covered	<u>Referral</u> is required *
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.*
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$20 / test for laboratory tests. \$40 / test for X-rays diagnostic imaging and ultrasounds.	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$100 / test	Not covered	<u>Prior Authorization</u> is Required.*
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.lacare.org/members/getting-care/pharmacy-services">http://www.lacare.org/members/getting-care/pharmacy-services</a>	Tier 1 - Most Generics	Retail - \$5 / script Mail Order - \$10 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. *
	Tier 2 -Preferred brand drugs	Retail - \$25 / script Mail Order - \$50 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Pharmacy <u>deductible</u> applies *
	Tier 3 - Non-preferred brand drugs	Retail - \$45 / script Mail Order - \$90 / script	Not covered	Up to 30-day supply for Retail Pharmacy. Up to 90-day supply for Mail Order Pharmacy. Pharmacy <u>deductible</u> applies *
	Tier 4 - <u>Specialty drugs</u>	15% up to \$150 per script	Not covered	<u>Prior Authorization</u> is Required. Mail order not available. Pharmacy <u>deductible</u> applies

\* For more information about limitations and exceptions, see the plan or policy document at [lacare.org](http://www.lacare.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. *
	Physician / surgeon fees Outpatient Visit	15% <a href="#">coinsurance</a> 15% <a href="#">coinsurance</a>	Not covered Not covered	None None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 / visit No charge for physician fee	\$150 / visit No charge for physician fee	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$75	\$75	None
	<a href="#">Urgent care</a>	\$15 / visit	\$15 /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. <a href="#">Deductible</a> applies *
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 / office visit 15% <a href="#">coinsurance</a> up to \$15 for other outpatient services	Not covered	<a href="#">Prior Authorization</a> is Required for Psychological Testing. *
	Inpatient services	15% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. <a href="#">Deductible</a> applies *
If you are pregnant	Office visits	No charge	Not covered	For prenatal care and preconception visits
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	Not covered	None
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies *
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$15 / visit	Not covered	Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. <a href="#">Prior Authorization</a> is Required. *
	<a href="#">Rehabilitation services</a>	\$15 / visit	Not covered	<a href="#">Prior Authorization</a> is Required. *
	<a href="#">Habilitation services</a>	\$15 / visit	Not covered	<a href="#">Prior Authorization</a> is Required. *
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a>	Not covered	Up to a maximum of 100 days per Calendar Year per Member. <a href="#">Prior Authorization</a> is

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Required. <a href="#">Deductible</a> applies *
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	Not covered	<a href="#">Prior Authorization</a> is Required. *
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Prior Authorization</a> is Required. *
If your child needs dental or eye care	Children's Eye exam	No charge	Not covered	1 visit per calendar year
	Children's Glasses	No charge	Not covered	1 pair of glasses per year (or contact lenses in lieu of glasses).
	Children's Dental check-up	No Charge	Not covered	Oral exam and preventive cleaning limited to 1 every 6 months. See your <a href="#">plan</a> document for additional information about services.

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

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

- Acupuncture
- Bariatric surgery
- Medical necessary routine foot care
- Services related to Abortion

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [lacare.org](#).

## 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: Department of Managed Health Care at **1 (888) HMO-2219 (1-888-466-2219)** or [hmohelp.ca.gov](http://hmohelp.ca.gov); U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or [www.cciio.cms.gov](http://www.cciio.cms.gov); Covered California at **1 (800) 300-1506** or [coveredca.com](http://coveredca.com); or contact L.A. Care Health Plan at **1- 855-270-2327** . 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](http://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 contact your rights, this notice, or assistance, contact L.A. Care Customer Service at **1- 855-270-2327**. Additionally, you can contact the California DMHC at **1-888-466-2219** or visit [dmhc.ca.gov](http://dmhc.ca.gov).

## Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through Covered California 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 Covered California

## Language Access Services:

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1- 855-270-2327**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1- 855-270-2327**

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1- 855-270-2327**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1- 855-270-2327**

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$1,400
- [Specialist \[cost sharing\]](#) \$25
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$1,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,910</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist \[cost sharing\]](#) \$25
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) \$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist \[cost sharing\]](#) \$2985
- Hospital (facility) [\[cost sharing\]](#) 15%
- Other [\[cost sharing\]](#) \$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$40
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$540</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Getting Help in Other Languages

### English:

Free language assistance services are available. You can request interpreting or translation services, information in your language or in another format, or auxiliary aids and services. Call L.A. Care at 1.855.270.2327 (TTY 711), 24 hours a day, 7 days a week, including holidays. The call is free.

### Spanish:

Los servicios de asistencia de idiomas están disponibles de forma gratuita. Puede solicitar servicios de traducción e interpretación, información en su idioma o en otro formato, o servicios o dispositivos auxiliares. Llame a L.A. Care al 1.855.270.2327 (TTY 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.

### Chinese:

提供免費語言協助服務。您可申請口譯或翻譯服務，您使用之語言版本或其他格式的資訊，或輔助援助和服務。請致電 L.A. Care 電話 1.855.270.2327 (TTY 711)，服務時間為每週 7 天，每天 24 小時（包含假日）。上述電話均為免費。

### Vietnamese:

Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Quý vị có thể yêu cầu dịch vụ biên dịch hoặc phiên dịch, thông tin bằng ngôn ngữ của quý vị hoặc bằng các định dạng khác, hay các dịch vụ và thiết bị hỗ trợ ngôn ngữ. Xin vui lòng gọi L.A. Care tại 1.855.270.2327 (TTY 711), 24 giờ một ngày, 7 ngày một tuần, kể cả ngày lễ. Cuộc gọi này miễn phí.

### Tagalog:

Available ang mga libreng serbisyo ng tulong sa wika. Maaari kang humiling ng mga serbisyo ng pag-interpret o pagsasaling-wika, impormasyon na nasa iyong wika o nasa ibang format, o mga karagdagang tulong at serbisyo. Tawagan ang L.A. Care sa 1.855.270.2327 (TTY 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga holiday. Libre ang tawag.

### Korean:

무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하는 통역 또는 번역 서비스, 귀하가 사용하는 언어 또는 기타 다른 형식으로 된 정보 또는 보조 지원 및 서비스 등을 요청하실 수 있습니다. 공휴일을 포함해 주 7일, 하루 24시간 동안 L.A. Care, 1.855.270.2327 (TTY 711)번으로 문의하십시오. 이 전화는 무료로 이용하실 수 있습니다.

### Armenian:

Տրամադրելի են լեզվական օգնության անվճար ծառայություններ: Կարող եք խնդրել բանավոր թարգմանչական կամ թարգմանչական ծառայություններ, Ձեր լեզվով կամ տարբեր ձևաչափով տեղեկություն, կամ օժանդակ օգնություններ և ծառայություններ: Չանգահարեք L.A. Care 1.855.270.2327 համարով (TTY 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոնական օրերը: Այս հեռախոսազանգն անվճար է:

### Farsi:

L.A. خدمات رایگان امداد زبانی موجود می باشد. می توانید برای خدمات ترجمه شفاهی یا کتبی، اطلاعات به زبان خودتان یا فرمت دیگر، یا امدادها و خدمات اضافی درخواست کنید. با Care 1.855.270.2327 (TTY 711) - به شماره تماس رایگان است. این تماس رایگان است. این تماس شامل تعطیل تماس بگیرید. این تماس رایگان است (TTY 711) - به شماره Care 1.855.270.2327 در 24 ساعت شبانه روز و 7 روز هفته شامل روزهای تعطیل تماس بگیرید.

**Russian:**

Мы предоставляем бесплатные услуги перевода. У Вас есть возможность подать запрос о предоставлении устных и письменных услуг перевода, информации на Вашем языке или в другом формате, а также вспомогательных средств и услуг. Звоните в L.A. Care по телефону 1.855.270.2327 (TTY 711) 24 часа в сутки, 7 дней в неделю, включая праздничные дни. Этот звонок является бесплатным.

**Japanese:**

言語支援サービスを無料でご利用いただけます。通訳・翻訳サービス、日本語や他の形式での情報、補助具・サービスをリクエストすることができます。L.A. Care までフリーダイヤル1.855.270.2327 (TTY 711) にてご連絡ください。祝休日を含め毎日 24 時間、年中無休で受け付けています。

**Arabic:**

L.A. Care خدمات المساعدة اللغوية متاحة مجاناً. يمكنك طلب خدمات الترجمة الفورية أو الترجمة التحريرية أو معلومات بلغتك أو بتنسيق آخر أو مساعدات وخدمات إضافية. اتصل بـ 1.855.270.2327 (711 TTY) على مدار الساعة وطوال أيام الأسبوع، بما في ذلك أيام العطلات. المكالمات مجانية.

**Panjabi:**

ਪੰਜਾਬੀ: ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਤੁਸੀਂ ਦੁਆਰੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ, ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫੋਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਸਹਾਇਕ ਉਪਕਰਣਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। L.A. Care ਨੂੰ 1.855.270.2327 (TTY 711) ਨੰਬਰ ਉੱਤੇ ਕਾਲ ਕਰੋ, ਇੱਕ ਦਿਨ ਵਿੱਚ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚ 7 ਦਿਨ, ਛੁੱਟੀਆਂ ਸਮੇਤ। ਕਾਲ ਮੁਫਤ ਹੈ।

**Khmer:**

សេវាជំនួយខាងភាសា គឺមានដោយឥតគិតថ្លៃ។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ ឬការបកប្រែ ស្នើសុំព័ត៌មាន ជាភាសាខ្មែរ ឬជំនួយផ្សេងទៀត ឬជំនួយប្រែប្រួល និងសេវា ទូរស័ព្ទទៅ L.A. Care តាមលេខ 1.855.270.2327 (TTY 711) បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។ ការហៅនេះគឺឥតគិតថ្លៃឡើយ។

**Hmong:**

Muaj kev pab txhais lus pub dawb rau koj. Koj tuaj yeem thov kom muab cov ntaub ntawv txhais ua lus lossis txhais ua ntawv rau koj lossis muab txhais ua lwm yam lossis muab khoom pab thiab lwm yam kev pab cuam. Hu rau L.A. Care ntawm tus xov tooj 1.855.270.2327 (TTY 711), tuaj yeem hu tau txhua txhua 24 teev hauv ib hnuv, 7 hnuv hauv ib vij thiab suab nrog cov hnuv so tib si, tus xov tooj no hu dawb xwb.

**Hindi:**

मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। आप दुभाषिया या अनुवाद सेवाओं, आपकी भाषा या किसी अन्य प्रारूप में जानकारी, या सहायक उपकरणों और सेवाओं के लिए अनुरोध कर सकते हैं। आप L.A. Care को 1.855.270.2327 (TTY 711) नंबर पर फ़ोन करें, दिन में 24 घंटे, सप्ताह में 7 दिन, छुट्टियों सहित। कॉल मुफ्त है।

**Thai:**

มีบริการช่วยเหลือภาษาฟรี คุณสามารถขอรับบริการการแปลหรือล่าม ข้อมูลในภาษาของคุณหรือในรูปแบบอื่น หรือความช่วยเหลือและบริการเสริมต่าง ๆ ได้ โทร L.A. Care ที่ 1.855.270.2327 (TTY 711) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์รวมทั้งวันหยุด โทรฟรี

**Lao:**

ພາສາອັງກິດ ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຮັບບໍລິການນາຍພາສາ ຫຼື ແປພາສາໄດ້, ສໍາລັບຂໍ້ມູນໃນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນ, ຫຼື ເຄື່ອງມືຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມ. ໃຫ້ໂທຫາ L.A. Care ໄດ້ທີ່ 1.855.270.2327 (TTY 711), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ, ລວມເຖິງວັນພັກຕ່າງໆ. ການໂທແມ່ນບໍ່ເສຍຄ່າ.