KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan.

- If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If someone in your family wants a different health plan, they must complete a separate application.
- To be eligible for KPIF coverage, you must live in our California service area.

Who should not use this application?

- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.
- Please note the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to California residents free of charge. Call HICAP at 1-800-434-0222 to learn more. See page 12 to find your local HICAP program information.
- If you qualify for and want federal or state financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Covered California at CoveredCA.com.
- To make changes to your existing KPIF account, call **1-800-464-4000** (TTY **711**).

Things to remember

- If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 31. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**.
- If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for instructions.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- Remember, enrolling in a new plan won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts.
- **To make sure your application is processed in time and isn't canceled,** please return every page of the application, completed, with all the required signatures, first month's payment, and proof of your qualifying life event (if required). Send these materials by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23127
  San Diego, CA 92193-9921

  Or send it by secure fax to: **1-866-816-5139**

  Note: Checks must be mailed and can't be faxed.

Need help?

- For help with completing this application, please call **1-800-494-5314** (TTY **711**).
- **We'll provide language assistance at no cost to you.**
- If you're working with a broker, please call them for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612.

Primary applicant

STEP 1: Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** (TTY **711**) for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, or placement for adoption or foster care
  - ☐ The first day of the month after we receive the application
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
  Note: In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Determination by Covered California of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums
- ☐ Release from incarceration
- ☐ Misinformation about enrollment in minimum essential coverage
- ☐ Provider network changes
- ☐ Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee
- ☐ Eligibility for app-based transportation or delivery network company health care stipend

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.

STEP 2: Choose your health plan

Choose one health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze	Silver	Gold	Platinum
☐ Kaiser Permanente – Bronze 60 HDHP HMO	☐ Kaiser Permanente – Silver 70 HMO Off Exchange	☐ Kaiser Permanente – Gold 80 HMO Coinsurance	☐ Kaiser Permanente – Platinum 90 HMO
☐ Kaiser Permanente – Bronze 60 HMO	☐ Kaiser Permanente – Silver 70 HMO 2850/50 PCP	☐ Kaiser Permanente – Gold 80 HMO	
☐ Kaiser Permanente – Bronze 60 HMO 7500/0% PCP	☐ Kaiser Permanente – Silver 70 HDHP HMO 3600/25% PCP	☐ Kaiser Permanente – Gold 80 HMO 0/30 PCP	

For applicants under 30 or with hardship exemptions

Minimum coverage plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **CoveredCA.com/exemptions** and follow the instructions.

☐ Kaiser Permanente – Minimum Coverage HMO

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-464-4000** (TTY **711**), or contact your broker.

Primary applicant

STEP 3: Choose your optional adult dental plan

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental insurance plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. Please refer to the Summary of Dental Benefits Coverage (SDBC) *Disclosure Matrix* for complete details of the KPIC dental plan by visiting **kp.org/kpic-dental**.

Please choose one option below.

- ☐ Yes. I am requesting enrollment in the KPIC dental insurance plan that is available to me as a supplemental option to my health plan coverage. Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the KPIC dental insurance plan. Once enrolled, I understand I can't cancel my dental coverage without also canceling my health plan coverage, except during open enrollment or a special enrollment period.
- ☐ No. I'm not interested in optional dental coverage.

STEP 4: Enter your information

Primary applicant

In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Home address (no P.O. boxes, please)

City

State | ZIP code | County | Phone (mobile phone if available)

Mailing address ☐ Check if same as home address

City

State | ZIP code

Preferred language spoken (if not English) | Preferred language read (if not English)

Email address

Is the primary applicant purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes

If Yes, what type: ☐ ICHRA ☐ QSEHRA

Under an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA), your employer will establish and fund an account to help you pay monthly individual plan premiums and out-of-pocket expenses as an alternative to traditional group health coverage.

Using an employer's HRA to help pay premiums and out-of-pocket expenses does not change your eligibility for a Kaiser Permanente Individual and Family plan.

Primary applicant

Parent or legal guardian

Please complete this section if the primary applicant is a child under 18.
The parent or legal guardian must be 18 or older.

First name | MI | Date of birth (mm/dd/yyyy)

Last name

Gender:
☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Preferred language spoken (if not English)

Preferred language read (if not English)

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by the state of California.

First name | MI | Choose one: ☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Former medical record number (if any) | State (if any)

Gender:
☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Parent(s)/Stepparent(s) to be covered

If you have more than 2 parent(s)/stepparent(s) to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender:
☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

2 First name | MI | Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any) | State (if any)

Gender:
☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Primary applicant

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any)

State (if any)

Gender:
Male Female
Undeclared

Social Security number (if any)

Relationship to primary applicant

2 First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any)

State (if any)

Gender:
Male Female
Undeclared

Social Security number (if any)

Relationship to primary applicant

3 First name

MI

Date of birth (mm/dd/yyyy)

Last name

Former medical record number (if any)

State (if any)

Gender:
Male Female
Undeclared

Social Security number (if any)

Relationship to primary applicant

Primary applicant

STEP 5: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application only. This person is called an authorized representative.

First name

MI

Last name

Phone (mobile phone if available)

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

STEP 6: Sign the application agreement

Important: All applicants, parent(s)/stepparent(s), and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then their parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 2 parent(s)/stepparent(s) and/or dependents 18 and older signing, please attach a copy of this page with the additional signatures. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- I understand that Kaiser Foundation Health Plan, Inc., will rely on the information provided in this application. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Foundation Health Plan, Inc., may choose to terminate coverage back to the coverage effective date.
- If I worked with a broker, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the broker or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- By providing my email address and mobile phone number, I understand I may receive email and text communications from Kaiser Permanente.

X

Primary applicant (parent or legal guardian for children under 18)

Date (mm/dd/yyyy)

X

Spouse/domestic partner

Date (mm/dd/yyyy)

X

Parent/stepparent

Date (mm/dd/yyyy)

X

Parent/stepparent

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

Primary applicant

STEP 7: Sign the Kaiser Foundation Health Plan, Inc., arbitration agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form.*

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Primary applicant (parent or legal guardian for children under 18)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Spouse/domestic partner

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Parent/stepparent

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Parent/stepparent

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

X _____ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application. If there are more than 2 parent(s)/stepparent(s) and/or dependents 18 and older signing, please attach a copy of this page with the additional signatures.

Primary applicant

STEP 8: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

ZIP code

Email address

Payment options (choose one) ☐ Electronic payment ☐ Check ☐ Money order ☐ Credit card ☐ Debit card

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer of the first month's payment amount from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

If check or money order

Write the name of the primary applicant on the check. Mail payment with your application to the address listed on page 1.

To pay with a credit or debit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

Primary applicant

Automatic monthly payments (optional)

To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-888-236-4490** (TTY **711**).

Do you want to sign up for automatic monthly payments?

- ☐ Yes
  - ☐ I want to enter a new payment method here. (Please fill out this page.)
  - ☐ Please use the same payment method I provided for my first month's payment. (Skip this page.)
- ☐ No, I don't want automatic monthly payments. (Skip this page)

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Email address

Automatic payment options

(choose one) ☐ Electronic payment ☐ Credit card (debit cards can't be used)

If electronic payment, select account type: ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc. (KFHP), and the designated financial institution to accept this transfer from my checking or savings account.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

To pay with a credit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

Primary applicant

For applicants using a broker or Kaiser Permanente representative

If a broker or Kaiser Permanente representative (employee) helped you decide which plan to enroll in or helped you fill out this application, please make sure they complete this page.

The broker may receive monetary payments or other compensation from Kaiser Permanente in connection with your purchase of this coverage.

Our standard compensation range is $13 -$19 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.

Note: Premiums are the same whether or not you use a broker or Kaiser Permanente representative.

To be completed by your broker or representative after you complete this application:

Notice to broker or Kaiser Permanente representative: If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

Agency name

Agency ID number

Broker or Kaiser Permanente representative (first, middle, last)

Address

City

State

ZIP code

Kaiser Permanente–appointed ID number

National producer number (NPN)

Phone (mobile phone if available)

Fax

Email address

You must answer the following question by selecting Yes or No:

I (the broker/Kaiser Permanente representative) have not made any representations to the applicant about any provisions, benefits, conditions, or limitations of the *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form* except through written materials furnished by KPIF. The applicant has been informed that the effective date of coverage is assigned by KPIF. I certify that the information supplied to me by the applicant has been truly and accurately recorded.

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Yes ☐ No

X

Broker or Kaiser Permanente representative

Date (mm/dd/yyyy)

Local HICAP Offices by California County

Alameda County
333 Hegenberger Road, Suite 850
Oakland, CA 94621
510-839-0393

Alpine, Amador, Calaveras, Mariposa, and Tuolumne Counties
19074 Standard Road, Suite A
Sonora, CA 95370
209-532-6272 ext. 226

Butte, Colusa, Glenn, Plumas, and Tehama Counties
25 Main Street, Room 202
Chico, CA 95929-0799
530-898-6716

Contra Costa County
400 Ellinwood Way
Pleasant Hill, CA 94523
Inside Contra Costa from a landline phone:
1-800-510-2020
Out of state: 925-655-1393

Del Norte County
1765 Northcrest Drive
Crescent City, CA 95531
707-464-7876

El Dorado, Nevada, Placer, Sacramento, San Joaquin, Sierra, Sutter, Yolo, and Yuba Counties
505 12th Street
Sacramento, CA 95814
1-800-434-0222
916-376-8915

Fresno and Madera Counties
5363 N. Fresno Street
Fresno, CA 93710
559-224-9117

Humboldt County
333 J Street
Eureka, CA 95501
707-444-3000

Imperial and San Diego Counties
5151 Murphy Canyon Road, Suite 110
San Diego, CA 92123
Imperial: 760-353-0223
San Diego: 858-565-8772

Inyo, Mono, Riverside, and San Bernardino Counties
Council on Aging Southern California
2280 Market Street, Suite 140
Riverside, CA 92501
909-256-8369

Kern County
5357 Truxtun Ave.
Bakersfield, CA 93301
661-868-1000

Kings and Tulare Counties
3350 W. Mineral King
Visalia, CA 93291
559-713-2875
1-800-434-0222

Lake, Marin, Mendocino, Napa, Solano, and Sonoma Counties
1129 Industrial Ave., Suite 201
Petaluma, CA 94954
1-800-434-0222
707-526-4108

Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties
1647 Hartnell Ave., Suite 8
Redding, CA 96002
530-223-0999

Los Angeles County
4601 Wilshire Blvd., Suite 160
Los Angeles, CA 90010
213-383-4519
Within L.A. County: 1-800-824-0780

Merced County
851 West 23rd Street
Merced, CA 95340
209-385-7550

Monterey County
247 Main Street
Salinas, CA 93901
831-655-1334

Orange County
2 Executive Circle, Suite 175
Irvine, CA 92614
714-560-0424

San Benito and Santa Cruz Counties
1777 A Capitola Road
Santa Cruz, CA 95062
831-462-5510

San Francisco County
601 Jackson Street, 2nd Floor
San Francisco, CA 94133
415-677-7520

San Luis Obispo and Santa Barbara Counties
528 South Broadway
Santa Maria, CA 93454
805-928-5663

San Mateo County
1710 S. Amphlett Blvd., Suite 100
San Mateo, CA 94402
650-627-9350

Santa Clara County
3100 De La Cruz Blvd., Suite 310
San Jose, CA 95054
408-350-3200, option 2

Stanislaus County
3500 Coffee Road, Suite 19
Modesto, CA 95355
209-558-4540

Ventura County
646 County Square Drive, Suite 100
Ventura, CA 93003
805-477-7310

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- 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 our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente[1] cumple con las leyes de derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, tales como:
  - intérpretes calificados de lengua de señas,
  - información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo para las personas cuya lengua materna no sea el inglés, como:
  - intérpretes calificados,
  - información escrita en otros idiomas.

Si necesita estos servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros las 24 horas del día, los 7 días de la semana (excepto los días festivos). La llamada es gratuita.

- Todos los miembros: **1-800-788-0616** (TTY **711**)

Al presentar una solicitud, este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos proporcionado estos servicios o lo hemos discriminado ilícitamente de otra forma. Puede presentar una queja por teléfono, correo postal, en persona o en línea. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede llamar a Servicio a los Miembros para informarse sobre las opciones que se apliquen a su caso o si necesita ayuda para presentar una queja. Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** todos los miembros pueden llamar al **1 800-788-0616** (TTY **711**). La ayuda está disponible las 24 horas del día, los 7 días de la semana (excepto los días festivos)**.**
- **Por correo postal:** descargue un formulario en **kp.org** o llame a Servicio a los Miembros y pida que se le envíe un formulario para que lo devuelva**.**
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios (Complaint or Benefit Claim/Request form) en una oficina de Servicio a los Miembros ubicada en un

[1] Kaiser Permanente incluye Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, y el Southern California Medical Group

centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).

- **En línea:** utilice el formulario en línea en nuestro sitio web en **kp.org**.

También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente a la siguiente dirección:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Los formularios de queja están disponibles en:
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov**.**

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al 1**-800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Los formularios de quejas están disponibles en
  https://www.hhs.gov/ocr/complaints/index.html

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

反歧视声明

歧视属于违法行为。Kaiser Permanente[1]遵守州和联邦的民权法律。

Kaiser Permanente不会因年龄、人种、族群认同、肤色、国籍、文化背景、血统、宗教、性别、性别认同、性别表现、性取向、婚姻状况、身体或精神残疾、医疗状况、付款来源、遗传信息、公民身份、主要语言或移民身份而非法歧视、排斥或区别对待任何人。

Kaiser Permanente 提供以下服务：

- 为残障人士提供免费援助和服务，帮助他们更有效地与我们沟通，例如：
  - ♦ 合格的手语翻译员
  - ♦ 其他格式的书面信息，例如盲文、大字体版本、音频、通用电子格式和其它格式
- 为母语非英语的人士提供免费语言服务，例如：
  - ♦ 合格的口译员
  - ♦ 其他语言的文字信息

如果您需要这些服务，请打电话给我们的会员服务联络中心，服务时间为每周7天，每天24小时（节假日除外）。此电话不收取任何费用：

- 所有会员：**1-800-757-7585** (TTY **711**)

根据您的要求，我们可以为您提供本文件的盲文版、大字版、卡式录音带或电子版。如需获取这些替代格式或其他格式的副本，请打电话给我们的会员服务联络中心，索取您需要的格式。

如何向Kaiser Permanente递交申诉

如果您认为我们未能提供这些服务或有其他形式的

非法歧视，您可以向Kaiser Permanente 提出歧视申诉。您可以通过电话、邮件、面谈或在线提出申诉。详情请见《承保范围说明书》*或*《保险证明》。您可以打电话给会员服务部，进一步了解适用于您的选项，或寻求帮助提交申诉。您可以通过以下方式提出歧视申诉：

- **电话：**所有会员均可拨打**1-800-757-7585** (TTY **711**)。每周7天、每天24小时提供帮助（节假日除外）
- **邮寄：**从 **kp.org**下载表格，或打电话给会员服务部，请他们给您寄一份表格，以供填写后寄回。
- **亲自提交：**在计划设施内的会员服务办公室填写投诉表或福利索赔表格（请在kp.org/facilities上的保健业者目录中查询地址）
- **在线提交：** 请在我们的网站**kp.org**上使用线上表格

[1] Kaiser Permanente包括Kaiser Foundation Health Plan, Inc、Kaiser Foundation Hospitals、Permanente Medical Group和Southern California Medical Group

您也可以直接联系Kaiser Permanente民权事务协调员，地址为：

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

如何向加州医疗保健服务部民权办公室提出申诉（仅适用于*Medi-Cal*受益人）

您也可以通过书面、电话或电子邮件向加州医疗保健服务部民权办公室提出民权投诉：

- **电话：**拨打**916-440-7370** (TTY **711**) 联系加州医疗保健服务部（California Department of Health Care Services, DHCS）民权办公室
- **邮寄：**填写投诉表或寄信到以下地址：

  Deputy Director, Office of Civil
  Rights Department of Health Care
  Services Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  投诉表可在此网址下载：**http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **线上：**发送电子邮件至CivilRights@dhcs.ca.gov

如何向美国卫生和民众服务部民权办公室提出申诉

您可以向美国卫生和民众服务部民权办公室提出歧视投诉。您可以通过书面、电话或在线方式投诉：

- **电话：**拨打**1-800-368-1019** (TTY **711** 或**1-800-537-7697**)
- **邮寄：填写投诉表或寄信到以下地址：**

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  投诉表可在此网址下载：
  https://www.hhs.gov/ocr/complaints/index.html
- **在线：**访问民权办公室投诉门户网站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente[1] tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.

Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
  - ♦ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
  - ♦ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
  - ♦ Thông dịch viên đủ trình độ
  - ♦ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Cuộc gọi này được miễn cước:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Quý vị có thể đệ trình phàn nàn qua điện thoại, thư tín, trực tiếp hay trực tuyến. Vui lòng tham khảo *Chứng Từ Bảo Hiểm (Evidence of Coverage)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)* của quý vị để biết thêm chi tiết. Quý vị có thể gọi cho ban Dịch Vụ Hội Viên để biết thêm thông tin về những lựa chọn áp dụng cho quý vị, hay để được trợ giúp đệ trình phàn nàn. Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Hội viên Medi-Cal có thể gọi **1-855-839-7613** (TTY **711**). Mọi hội viên khác có thể gọi **1-800-464-4000** (TTY **711**). Sự trợ giúp được miễn phí, 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)

[1] Kaiser Permanente bao gồm Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, và Southern California Medical Group

- **Qua thư tín:** Tải xuống một mẫu đơn tại **kp.org** hay gọi ban Dịch Vụ Hội Viên và yêu cầu họ gửi cho quý vị một mẫu đơn mà quý vị có thể gửi lại.
- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California *(Dành Riêng Cho Người Thụ Hưởng Medi-Cal)*

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Mẫu đơn than phiền hiện có tại: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Mẫu đơn than phiền hiện có tại
  https://www.hhs.gov/ocr/complaints/index.html

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language or alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬឯកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយ ទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរស័ព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបិទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ປິດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix**: 1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000 (TTY 711)**

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000 (TTY 711)**