KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

California

Instructions

- If you are an existing Kaiser Permanente for Individuals and Families (KPIF) member enrolled directly into a KPIF account, you may use this form to make plan changes or account changes. Only the subscriber or parent/legal guardian of a child-only account can fill out this form.
- If you are an existing KPIF member enrolled through Covered California, all account and plan changes to your existing coverage must be requested through CoveredCA.com. If you are not sure how you are enrolled or need additional support, please call **1-800-255-5169** (TTY **711**).
- There are different types of plan changes and account changes you can make with this form. Please fill out your personal information in Section A. Then select what changes you'd like to make in Section B, and continue on to fill out any other sections related to those changes.
- If you are a subscriber ending coverage, your dependents' coverage automatically ends. You may choose to keep your children under 21 years of age on a child-only account. If you're ending KPIF coverage because you are newly eligible for Group coverage or Medicare, your dependents have a Special Enrollment Period to enroll in new KPIF coverage. Go to **kp.org/specialenrollment** or contact Member Services to learn more.
- If you're adding a dependent to your plan, any other coverage they have won't be automatically canceled unless stated in this form. To avoid paying for 2 plans or having a gap in coverage, please cancel any other coverage they have as of the day before their new coverage starts.
- Note: If you're entitled to Medicare Part A or enrolled in Medicare Part B, you're not eligible to change KPIF plans. If a family member is entitled to Medicare Part A or enrolled in Medicare Part B, they're not eligible to change KPIF plans or be added to your KPIF plan as a new dependent.
- 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 8 to find your local HICAP program information.

A. Fill out your information

If you're making a change, please update the boxes below with your new information.

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

Last name

Medical record number (if any)

Gender: ☐ Male ☐ Female ☐ Undeclared

Social Security number (if any)

Home address (no P.O. boxes)

City

State | ZIP code | County | Primary phone (mobile phone, if available)

Email address

Mailing address ☐ Check if same as home address

City

State | ZIP code

B. What change(s) do you want to make?

Please check the boxes below for the changes you wish to make and list each family member affected. We won't make any changes for any family members you don't list.

You can make the following changes during open enrollment or a special enrollment period. To make a change other than listed below, you can call Member Services at **1-800-464-4000** (TTY **711**).

- ☐ Change plans.
- ☐ Add medical coverage for a family member.
- ☐ Change my child-only account to a family account with myself as the subscriber.
- ☐ Add optional adult dental coverage (for all members 19 and older on my plan).
- ☐ End optional adult dental coverage (for all members 19 and older on my plan).

(Restrictions apply for special enrollment periods. See **kp.org/specialenrollment** for more information.)

Combine KPIF Accounts

Accounts can be combined during open enrollment or a special enrollment period.

☐ I wish to add (a) family member(s) that is already on a KPIF plan to my account. Doing this will end their existing plan. (Please indicate which family member(s) will move to your account in Section C.)

Account Ending

First name | MI

Last name

Subscriber medical record number for account ending

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Subscriber or parent/legal guardian for account ending

You can make the following changes any time during the year. *(Note: For these changes, you can skip Sections D and E.)*

- ☐ End all coverage for myself and all family members.
- ☐ End all coverage for a family member.
- ☐ End my coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ End my and my spouse's/domestic partner's coverage and keep my child(ren) under 21 years of age on a child-only account.
- ☐ Make the changes shown in Section A. (If you're changing your name, please include legal documentation of the change.)

Requested effective date (not guaranteed)

☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

C. Which family members are affected by the change? (Please list below.)

Spouse/Domestic partner

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Date of birth (mm/dd/yyyy) / / | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Medical record number (if any) | Primary phone (mobile phone, if available) - -

Email address

If you have more than 2 parent(s)/stepparent(s) with a change, attach a copy of this page and complete the information for those parent(s)/stepparent(s).

Parent/Stepparent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email address

Parent/Stepparent 2

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email address

C. Which family members are affected by the change? (Please list below.)

If you have more than 3 dependents with a change, attach a copy of this page and complete the information for those dependents. Provide phone and email for dependents aged 18 and over only.

Dependent 1

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email address

Dependent 2

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email address

Dependent 3

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add optional adult dental coverage ☐ End optional adult dental coverage

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

Last name

Medical record number (if any) | Gender ☐ Male ☐ Female ☐ Undeclared | Social Security number (if any) - -

Primary phone (mobile phone, if available) - -

Email address

D. Choose your enrollment period

Select one option: ☐ Open enrollment **(skip to Section E)** ☐ 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.

Change in health coverage

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Discontinuation of employer contribution or government subsidization of COBRA premiums
- ☐ Misinformation about your enrollment in minimum essential coverage
- ☐ Provider network changes
- ☐ Eligibility for app-based transportation or delivery network company health care stipend

Change in household

- ☐ 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 form
- ☐ 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
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent

Change in residence

- ☐ Permanent relocation within the United States with access to new plans
- ☐ Permanent relocation to the United States from another country

  Note: Please check one of the following boxes:
  - ☐ U.S. citizen/permanent resident
  - ☐ Non-U.S. citizen

Other qualifying life events

- ☐ Determination by Covered California of exceptional circumstances
- ☐ Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee
- ☐ Release from incarceration

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

E. Choose your health plan

If you indicated that you would like to change plans or add coverage for a family member, please select the plan you would like here. Each family member you listed in Section C will be moved to the plan you select. If you wish to enroll family members in different plans, please submit a separate form for each plan.

- ☐ Kaiser Permanente – Bronze 60 HDHP HMO
- ☐ Kaiser Permanente – Bronze 60 HMO
- ☐ Kaiser Permanente – Bronze 60 HMO 8200/0% PCP
- ☐ Kaiser Permanente – Silver 70 HMO Off Exchange
- ☐ Kaiser Permanente – Silver 70 HMO 2850/50 PCP
- ☐ Kaiser Permanente – Silver 70 HDHP HMO 4000/25% PCP
- ☐ Kaiser Permanente – Gold 80 HMO Coinsurance
- ☐ Kaiser Permanente – Gold 80 HMO
- ☐ Kaiser Permanente – Gold 80 HMO 0/30 PCP
- ☐ Kaiser Permanente – Gold 80 HMO 750/35 PCP
- ☐ Kaiser Permanente – Gold 80 HDHP HMO 2500/15% PCP
- ☐ Kaiser Permanente – Platinum 90 HMO
- ☐ Kaiser Permanente – Minimum Coverage HMO*

***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.

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.

F. 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.

You can enroll in or end adult dental coverage in the optional dental insurance plan during open enrollment, annual member renewal, or a special enrollment period. 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**.

☐ Add optional adult dental coverage.†

☐ End optional adult dental coverage.†

†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.

G. Sign the form

- I understand that Kaiser Foundation Health Plan, Inc. will rely on the information I provide in this form, and that if any information is found to be fraudulent or intentionally misrepresented, Kaiser Foundation Health Plan, Inc. may choose to terminate my coverage back to the coverage effective date.
- I verify that no one listed on this form who is changing plans or being added as a dependent is entitled to Medicare Part A or enrolled in Medicare Part B.
- If I worked with a broker, I understand they may receive monetary payments or other compensation from Kaiser Permanente in connection with this coverage. Our standard compensation is $14 per member per month plus a potential bonus. To learn more, visit **kp.org/brokercompensation**.
- By providing my email address and phone number(s), I understand I may receive email and/or voice/text communications from Kaiser Permanente. For more information visit **healthy.kaiserpermanente.org/termsconditions**.

Note: The subscriber must sign the form. All new dependents 18 and older including parent(s)/stepparent(s) must also sign the form. If there are more than 2 dependents 18 and older and 2 parent(s)/stepparent(s) signing, please attach a copy of this page with the additional signatures.

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

Subscriber/new subscriber (parent or legal guardian for subscribers 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)

H. 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*.

The subscriber must sign the form. All new dependents 18 and older including parent(s)/stepparent(s) must also sign the form. If there are more than 2 dependents 18 and older and 2 parent(s)/stepparent(s) signing, please attach a copy of this page with the additional signatures.

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)

The applicant or their authorized representative may request a copy of the completed form. For more information, please call **1-800-464-4000** (TTY **711**).

Contact information

Mail to: Kaiser Permanente P.O. Box 23127 San Diego, CA 92193-9921	**Or fax toll free to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-800-464-4000** (TTY **711**)

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
3333 Soquel Drive, Suite A
Soquel, CA 95073
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
4651 Telephone Road
Ventura, CA 93003
805-477-7310

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not 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 in a timely manner:

- 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 Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

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

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us 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:** Call our Member Services department. Phone numbers are listed above.
- **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.
- **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 for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for 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:

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

  California Department of Health Care Services Office for Civil Rights 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 for 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

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member Services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية الفورية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل بقسم خدمات الأعضاء (Member Services) لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على : **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների

սպասարկման բաժին (Member Services): Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意。我们可及时提供免费语言协助。您可以要求获取口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部 (Member Services) 以获取帮助。重要节假日期间会员服务不开放。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- 加州医疗保健辅助计划：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی از مساعدت زبانی بموقع به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای (Member Services) ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**)، از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर दी जाने वाली भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग (Member Services) को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb ncav sij hawm rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab (Member Services). Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese: ご注意。必要に応じた言語サポートを、無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービス (Member Services) は主要な休日では営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។
ជំនួយភាសាទាន់ពេលវេលាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ទាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិក (Member Services) របស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀត៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

Korean: 안내 사항. 시기적절한 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**) 번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງທັນເວລາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ, ເຊັ່ນ: ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສຳຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv jiepv sih liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn Ziux Goux Baengc Mienh Nyei Dorngx (Member Services) liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍŁTĮĮH. T'áá Áko T'áá Ałtso K'ad Díí T'áá Bíní'dée'go Bizaad Bee Na'anish Bééhózin, Doo Béeso Bee Na'al'a' Da. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Nihí Diné Bináhásdzą́ Baa Anáál'įį'ígíí Na'anish (Member Services) Bá Haz'ą́ Bii' Bee Áká Shich'į' Hodiilnih. Dinéełchí Na'anish Bá Haz'ą́ Éí 'Ayóó'át'éego Niheezhch'įjhgo Yáá'ah Nits'ááh Daaztsáál.

- Medicare, bikáa’ dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t’ááłá’í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį, 7 jį t’ááłá’í damóo
- T’áá ał’ąą: **1-800-464-4000** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį, 7 jį t’ááłá’í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные и своевременные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (TTY **711**), без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (TTY **711**), круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000** (TTY **711**), круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), de 8 a. m. a 8 p. m., los 7 días de la semana.
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na mabilis na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang lingo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านแบบทันทีโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิก (Member Services) ของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น. หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của

chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-788-0710** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

KPIC Civil Rights Coordinator
P.O. Box 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710

You may also contact the California Department of Insurance regarding your complaint.

By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Electronically:
www.insurance.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file the complaint 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
Phone:1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

Notice of Language Assistance

No Cost Language Services. You can get an interpreter and get documents read to you in your language. You may also request for materials to be translated into your language or alternative formats sent to you. For help, call us at the number listed on your ID card or 1-800-788-0710. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios de idioma sin costo. Puede obtener servicios de un intérprete y que le lea documentos en su idioma. También puede solicitar que se traduzcan materiales a su idioma o que se le envíen en formatos alternativos. Si necesita ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-788-0710. Para obtener más información, llame al Departamento de Seguros de California al 1-800-927-4357. Los usuarios de TTY deben llamar al 711. Spanish

免費語言服務。您可使用口譯員並請人使用您的語言將文件唸給您聽。您也可以要求將資料翻譯成您的語言或以替代格式寄給您。如需幫助，請致電您會員證上所列的電話號碼或致電1-800-788-0710與我們聯絡。如需進一步幫助， 請致電1-800-927-4357與加州保險部聯絡。 TTY使用者請致電711。Chinese

Bizaad bee áko t’áá íiyisí bá oolzinígíí. Díí bizaad bee naaltsoos nihá ályaaígíí t’áá íiyisí yíníłta’go bee hane’ doo naaltsoos nihá níłtsą. Díí naaltsoos nihá bą́ąh yáhoot’éél doo tł’oh yáti’ígíí éí nihá bą́ąh yáhoot’éélígíí t’áá íiyisí bee ná’álkidgo nihá dah naashá. Ákót’éego baa ahéeh ná’ídílwo’, doo bik’ehgo naaltsoos bee naaznilígíí bikáá’ dah naashá ID béésh bee hane’gi t’áá ájít’éego bee hodíílnih doo 1-800-788-0710 áłtsé. Díkwíí hóló holne’go, California Béeso Bee Hane’ Áłchíní Bá Hooghan bee 1-800-927-4357 bibeeso biká anilyeed. TTY yáhoot’éél nihá shikaad 711. Navajo

Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên và người đọc thông tin giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Quý vị cũng có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc gửi đến quý vị các định dạng thay thế. Để được giúp đỡ, hãy gọi chúng tôi theo số điện thoại ghi trên thẻ Nhận Dạng (thẻ ID) của quý vị hoặc số 1-800-788-0710. Để được giúp đỡ thêm, vui lòng gọi Sở Bảo Hiểm CA theo số 1-800-927-4357. Người dùng TTY gọi số 711. Vietnamese

무료 언어 서비스. 통역사를 통해 사용하시는 언어로 서류를 읽어드립니다. 또한 사용하시는 언어로 자료를 번역해달라고 요청하거나 대체 형식으로 보내달라고 요청하셔도 됩니다. 도움이 필요한 경우, 회원 신분증에 적힌 번호나 1-800-788-0710번으로 문의하십시오. 추가로 도움이 필요한 경우, 캘리포니아주 보험국 전화번호 1-800-927-4357번으로 문의하시기를 바랍니다. TTY 사용자는 711번으로 전화하십시오. Korean

Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng interpreter at ipabasa ang mga dokumento sa inyong wika. Maaari rin kayong humiling na ang mga materyal ay isalin sa inyong wika o ipadala sa inyo sa mga alternatibong format. Para sa tulong, tawagan kami sa numero na nakalista sa inyong card ng pagkakakilanlan o sa 1-800-788-0710. Para sa higit pang tulong tumawag sa Departamento ng Insurance ng California sa 1-800-927-4357. Ang mga gumagamit ng TTY ay dapat tumawag sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ, և փաստաթղթերը կարող են ընթերցել ձեզ համար ձեր լեզվով: Կարող եք նաև խնդրել, որ նյութերը թարգմանվեն ձեր լեզվով կամ ուղարկվեն ձեզ այլընտրանքային ձևաչափերով: Օգնության համար զանգահարեք մեզ ձեր նույնականացման քարտի վրա նշված համարով կամ 1-800-788-0710 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության վարչություն 1-800-927-4357 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги переводчика. Вы можете воспользоваться услугами переводчика, и документы будут прочтены для вас на вашем языке. Вы также можете подать запрос о переводе материалов на ваш язык или в альтернативные форматы. Если вам требуется помощь, звоните нам по телефону, указанному на вашей идентификационной карте, или по телефону 1-800-788-0710. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Пользователям линии TTY следует звонить по телефону 711. Russian

無料の言語サービス。 通訳を手配し、書類をあなたの言語で読み上げてもらうことができます。また、ご希望があれば資料をあなたの言語に翻訳したり、別の形式でお届けすることも可能です。サポートが必要な場合は、身分証明カードに記載されている電話番号、または1-800-788-0710にお電話ください。さらにサポートが必要な場合は、カリフォルニア州保険局まで1-800-927-4357にご連絡ください。TTYユーザーの方は、711までお電話にてご連絡ください。Japanese

خدمات زبانی رایگان. می‌توانید یک مترجم شفاهی داشته باشید و ترتیبی بدهید تا اسناد به زبان خودتان برای شما خوانده شود. همچنین می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شود یا در قالب‌های جایگزین برای شما ارسال گردد. برای دریافت کمک و راهنمایی، با شماره مندرج در کارت شناسایی یا 1-800-788-0710 با ما تماس بگیرید. برای دریافت راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY می‌توانند با شماره 711 تماس بگیرند. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸਹਾਇਤਾ ਨਾਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹਵਾ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਜਾਂ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟਾਂ ਦੀ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਸਹਾਇਤਾ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਜਾਂ 1-800-788-0710 'ਤੇ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫ਼ੋਨ ਕਰੋ। ਪੰਜਾਬੀ Punjabi

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែនិងទទួលបានឯកសារអានជូនអ្នក ក្នុងភាសារបស់អ្នក។ អ្នកក៏អាចស្នើសុំឯកសារដើម្បីបកប្រែក្នុងភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀត ត្រូវបានផ្តើទៅអ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកលេខដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬទៅលេខ 1-800-788-0710។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅនាយកដ្ឋានជានាវ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាលេខ 1-800-927-4357។ អ្នកប្រើប្រាស់ TTY សូមហៅទៅលេខ 711។ Khmer

خدمات لغوية بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك بلغتك. يحق لك أيضاً طلب إرسال وثائق مترجمة بلغتك أو صيغ بديلة.للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية الخاصة بك أو 1-800-788-0710. لمزيد من المساعدة اتصل بقسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. على مستخدمي TTY الاتصال على الرقم 711. العربية Arabic

Kev Pab Txhais Lus Dawb. Koj tuaj yeem txais ib tug kws txhais lus thiab txais kev nyeem cov ntaub ntawv ua koj hom lus. Koj tuaj kheev thov kom muab cov ntaub ntawv txhais mus ua koj hom lus los sis xa ua lwm hom ntawv tuaj rau koj huv si. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj uas sau nyob rau ntawm koj daim npav cim thawj los sis 1-800-788-0710. Rau kev pab ntxiv, hu rau CA Chaw Ua Hauj Lwm Tswj Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

बिना किसी लागत के भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और दस्तावेज़ आपको आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। आप सामग्रियों को अपनी भाषा या आपको भेजे जाने वाले वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी अनुरोध कर सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-788-0710 पर हमें कॉल करें। अधिक सहायता के लिए कैलिफोर्निया डिपार्टमेंट ऑफ इंशोरेंस को 1-800-927-4357 पर कॉल करें। TTY प्रयोक्ता 711 पर कॉल करें। हिंदी: Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอใช้บริการล่ามและบริการอ่านเอกสารให้ฟังเป็นภาษาของคุณได้ คุณอาจขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นที่ส่งถึงคุณได้ หากต้องการความช่วยเหลือ โปรดติดต่อหมายเลขโทรศัพท์ที่ปรากฏบนบัตรประจำตัวของคุณหรือติดต่อหมายเลข 1-800-788-0710 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อกรมการประกันภัยของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 ผู้ใช้เครื่อง TTY โปรดติดต่อหมายเลข 711 Thai