Proof of qualifying life event form

Who should use this form?

- A qualifying life event is a change in your life that lets you apply for health care coverage outside the annual open enrollment period. This is called a special enrollment period. Examples include getting married, moving to a Kaiser Permanente service area with access to new health plans, or losing coverage because you lost your job.
- Use this Proof of Qualifying Life Event Form to submit your proof when applying directly to Kaiser Permanente if you or a dependent had a qualifying life event. You may also use this form to submit your proof when applying to your state's health benefit exchange in Colorado or Washington. For all other exchange applications, check your state's exchange for information on how to submit proof for exchange plans. It can help you figure out which type of proof you'll need to provide for your qualifying life event.
  - **Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with the Account Change Form.
  - **People who aren't Kaiser Permanente for Individuals and Families (KPIF) plan members** should submit their proof along with their Application for health coverage.

Who should not use this form?

- 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. Visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage.

How to use this form

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington

- Fill out Steps 1, 2, and 3.
- Submit this form and proof of your qualifying life event with your application or Account Change Form (if applicable). See "Submitting your proof" on page 16 for details.

When to submit your proof

California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington

You have a limited period of time to submit your proof. Visit **kp.org/specialenrollment** for details and deadlines.

If we don't get your proof in time, we'll have to cancel your application or account change request. You may apply again if your special enrollment period is still in effect.

For applications submitted on **buykp.org**, submit your proof online.

Need help?

Visit **kp.org/specialenrollment** for a comprehensive qualifying life event list.
You can also call us at **1-800-494-5314** (TTY **711**), or contact your broker/producer or Kaiser Permanente representative.

Primary applicant name

STEP 1: Primary applicant information

Who is the primary applicant?

- In an individual plan, the primary applicant is the person who'll be covered by the health plan.
- In a family plan, the primary applicant is the family member on the health plan who's authorized to make changes to the account.
- In a child-only plan (where offered) for a child under 18, the child is the primary applicant.

Please note: This isn't an application for health care coverage. To get health care coverage, you need to submit an application or Account Change Form.

First name

MI

Date of birth (mm/dd/yyyy)

Last name

Phone (mobile phone if available)

Application ID number (if you applied online)

Social Security number (if any)

Medical record number (if any)

Home address (no P.O. boxes)

City

State

ZIP code

Parent/legal guardian (if primary applicant is under 18)

First name

Last name

Broker/producer or Kaiser Permanente representative (if any)

First name

Last name

STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying event (mm/dd/yyyy)

For loss of minimum essential health coverage, the date of the qualifying event is the last full day you were covered under your prior plan.

Primary applicant name

STEP 3: Proof of your qualifying life event

- Check one box for your qualifying life event and one box for the proof you're sending (unless otherwise noted). Make sure the qualifying event and the type of proof apply to your state.
- Send one type of proof, unless otherwise noted.
- Send copies of official documents, not originals.
- Write this information about the primary applicant on the first page of your proof or on an attached page:
  - First and last name
  - Home address (no P.O. boxes)
  - Medical record number (if any)
  - Date of birth

Qualifying life event	Type of proof
☐ **1. Loss of minimum essential health coverage** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington[†] Important: This is NOT a qualifying life event if: • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and don't have any other coverage. • You voluntarily ended your coverage. • You had temporary or short-term coverage like traveler's insurance.	**From your employer** ☐ Letter or other document from your employer stating the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date this coverage ended or will end. ☐ Letter or document from your employer stating the employer stopped or will stop contributing to the cost of coverage and the date this contribution ended or will end. ☐ Pay stubs of current and previous hours if you lost coverage because of a reduction in work hours. ☐ Letter or document that indicates your coverage is ending due to age. **From COBRA** ☐ Letter showing your employer's offer of COBRA coverage or stating when your COBRA coverage ended or will end. We must receive your application within 60 days of the date when your COBRA coverage will end as stated on your proof. ☐ Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end. **From your carrier or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your carrier showing a coverage end date. ☐ Letter or notice from Medicaid, Medi-Cal, or the Children's Health Insurance Program (CHIP) stating when Medicaid, Medi-Cal, or CHIP coverage ended or will end. ☐ Letter or notice from a government program, like TRICARE, Peace Corps, AmeriCorps, or Medicare, stating when that coverage ended or will end.

[†]In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Loss of minimum essential health coverage *(continued)* California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	**Other loss of coverage (including individual coverage)** ☐ Letter from your student health plan indicating when student health coverage ended or will end. ☐ Letter or other document from Social Security office stating that the person who covers you on their health plan is entitled to Medicare. ☐ Letter or other document from an employer stating that the person who covers you on their health plan is starting new employer coverage. ☐ Dated military discharge papers or Certificate of Release, including the date coverage ended or will end, if you're losing coverage because you're no longer on active military duty. ☐ Dated and signed written verification from a broker/producer or Kaiser Permanente representative, or dated letter from the carrier, if you are or were enrolled in a non-calendar-year plan that's ending, including the date the plan ended.
Loss of minimum essential health coverage *(continued)* Colorado Important: This is NOT a qualifying life event if: • You're losing coverage because you didn't pay your premiums. • Your plan was rescinded. • You had Medicare Part B coverage and don't have any other coverage. • You voluntarily ended your coverage.	No proof required with your application.
☐ **2. Loss of pregnancy related coverage or loss of access to health care services through coverage provided to a pregnant woman's unborn child** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **3. Loss of medically needy coverage** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP) stating when Medicaid or CHIP coverage ended or will end.
☐ **4. Enrollment in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (QSEHRA)** Maryland	☐ Dated and signed written verification from an agent/broker/producer or dated letter from the carrier, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended.
5. Gaining, becoming, or losing a dependent, or death of a subscriber or a dependent	
☐ **5a. Gaining or becoming a dependent through marriage** **Check 2 boxes total.** District of Columbia, Virginia This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide one of these:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage.
☐ **5b. Gaining or becoming a dependent through marriage or domestic partnership registration** **Check 2 boxes total.** California, Georgia, Hawaii, Maryland, Oregon, Washington† This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Marriage certificate/license showing the date of the marriage. ☐ Official government record of the marriage, including a foreign record of marriage showing the date of the marriage. ☐ Official government record, including date of domestic partnership registration.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **5c. Gaining or becoming a dependent through marriage or civil union partnership** **Check 2 boxes total.** Colorado† This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**Provide one of these:** Proof of minimum essential coverage for one spouse for at least one full day in the last 60 days from your prior carrier (applicants within the U.S. only): ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **If you can't provide proof of minimum essential coverage, you may send in one of the following:** ☐ Official documentation showing that you are an American Indian or Native Alaskan. ☐ Proof that you lived for one or more days during the 60 days before your life event or during your most recent open enrollment period in a service area where no qualified health plan was available through your state's health benefit exchange. You can provide a screenshot from the exchange website or other proof from the exchange. ☐ Proof that you lived outside of the United States or in a United States territory for one or more days during the 60 days before the date of the qualifying life event. **And provide one of these:** ☐ Marriage certificate/license/other documentation showing the date of the marriage. ☐ Official government record, including date of civil union.
☐ **5d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. ☐ Record from a clinic, hospital, doctor, midwife, institution, or other provider stating the child's date of birth. ☐ Military record showing the child's birth date and place of birth. ☐ Official government record of a foreign birth certificate showing the child's birth date and place of birth. ☐ Religious record showing the child's birth date and place of birth. ☐ Letter or other document from the carrier, like an Explanation of Benefits, showing that services related to birth or after-birth care were given to the child, the mother, or both, including the dates of service. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
5d. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care *(continued)* Colorado†	**Birth of a child** ☐ Birth certificate or application for a birth certificate for the child. **Adoption or foster care** ☐ Adoption letter or record showing date of adoption, dated and signed by a court official. ☐ Court order showing when the order started. It must have a court filing date stamp. ☐ Official government record of a domestic adoption, or placement for adoption or foster care, showing the child's birth date and place of birth. ☐ U.S. Department of Homeland Security immigration document for foreign adoptions, including the date of the adoptions. ☐ Medical support court order. It must have a court filing date stamp. ☐ Foster care papers dated and signed by a court official.
☐ **5e. Losing a dependent through divorce, dissolution of domestic partnership, or legal separation** California, Maryland	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **5f. Losing a dependent through divorce, dissolution of a civil union partnership, or legal separation** Colorado†	☐ Divorce decree, dissolution agreement, or separation agreement with court filing date stamp.
☐ **5g. Death of the subscriber or a dependent** California, Maryland	☐ Death certificate.
Colorado†	☐ Death certificate or obituary.
☐ **6. Child support order or other court order to cover a dependent** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	☐ Signed court order with court filing date stamp.
Colorado†	☐ Signed court order with court filing date stamp or dated Designated Beneficiary Agreement.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **7. Permanent relocation with access to new plans** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington† Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan. This event requires proof of prior coverage. Visit **kp.org/specialenrollment** for more information.	**If you have permanently relocated (moved) to the United States from another country** **Send the following:** ☐ Signed naturalization papers, green card, education certificate, or visa dated within the last 60 days. **If you have permanently relocated (moved) within the United States** **Send a total of three pieces:** **1) One of the following proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days:** ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **2 and 3) Within 60 days of your move: one of the following items showing your previous address and one showing your current address (no P.O. Boxes):** ☐ Lease or rental agreement. ☐ Insurance documents, like homeowner's, renter's, or life insurance policy or statement. ☐ Mortgage deed, if it states the owner uses the property as the primary residence. ☐ Mortgage or rental payment receipt. ☐ Mail from the Department of Motor Vehicles, like a valid driver's license, vehicle registration, or change of address card. ☐ Mail from a government agency to your address, like a Social Security statement, or a notice from Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program. ☐ Your valid state ID. ☐ Internet, cable, or other utility bill (including any public utility like a gas or water bill) or other confirmation of service (including a utility hookup or work order). ☐ Telephone bill showing your address (cellphone or wireless bills are OK). ☐ Mail from a financial institution, like a bank statement. ☐ U.S. Postal Service change of address confirmation letter. ☐ Pay stub showing your address. ☐ Voter registration card showing your name and address. ☐ Documents from the Department of Corrections, jail, or prison showing recent release or parole, including a dated order of parole, dated order of release, or an address certification.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
Permanent relocation with access to new plans *(continued)* Colorado Choose **Permanent relocation with access to new plans**, if one of the following applies to you: • You moved from a non–Kaiser Permanente area to a Kaiser Permanente area. • You moved to a new residence within our Kaiser Permanente service area where your current health plan is not available or you have additional health plan options. • You moved to a new state. • You moved from a foreign country or a United States territory. • You moved from a county that did not offer a qualified health plan.	No proof required with your application.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **8. Changes in employer health coverage making you eligible for a premium tax credit** California, Georgia, Hawaii, Oregon, Colorado†, District of Columbia, Maryland, Virginia, Washington† You must apply through your state's health benefit exchange **You're now eligible for a premium tax credit because your coverage through your employer has changed.**	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.
☐ **9. Determination by your state's health benefit exchange of exceptional circumstances** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	☐ Letter or notice from your state's health benefit exchange stating you're eligible for a special enrollment period and showing determination date.
☐ **10. Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	☐ Letter or other documentation stating you are now eligible to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA) including the date showing when you are first eligible for the ICHRA or QSEHRA.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **11. Domestic violence or spousal abandonment occurring within the household** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	☐ Attestation stating you're a victim of domestic abuse or spousal abandonment.
☐ **12. Discontinuation of employer contribution or government subsidization of COBRA premiums** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington†	☐ Proof from your employer or COBRA administrator showing subsidies had been provided and the date they will end.
Colorado	No proof required with your application.
☐ **13. Release from incarceration** California, Colorado	No proof required with your application.
District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington	If you were recently released from incarceration (jail), you'll have to apply through your state's health benefit exchange. No proof is required.
☐ **14. Misinformation about your enrollment in minimum essential coverage** California	☐ Notice from your state's health benefit exchange or the Department of Managed Health Care stating you're eligible for a special enrollment period and showing determination date.
☐ **15. Provider network changes** California	☐ Notice that the provider is no longer participating in the health benefit plan and showing determination date.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **16. Demonstrating that a qualified plan substantially violated a material provision of its contract in relation to the enrollee** California	☐ Written confirmation, with date, from the Department of Managed Health Care that the health plan in which you're enrolled has substantially violated a material provision of your contract.
Colorado	No proof required with your application.
Maryland	☐ Written confirmation, with date, from the Maryland Insurance Administration that the health plan in which you're enrolled has substantially violated a material provision of your contract.
☐ **17. Eligibility for app-based transportation or delivery network company health care stipend** California	☐ A copy or a screen shot of your quarterly hours driven.
☐ **18. Determination by the Department of Insurance Commissioner of exceptional circumstances** Colorado†	☐ Letter or notice from the Department of Insurance Commissioner stating you're eligible for a special enrollment period and showing determination date.
☐ **19. Loss of Short Term Health Coverage** Colorado	No proof required with your application.
☐ **20. Initial confirmation of pregnancy by a health care practitioner** Maryland	☐ Document from your health care provider confirming your initial pregnancy. You have 90 days from the time your pregnancy is confirmed to enroll.
Colorado†	☐ Document from your health care provider confirming your initial pregnancy.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **21. Change in employer health coverage making you ineligible for a premium tax credit or change in eligibility for cost share reductions** Maryland	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating the employer changed or will change coverage or benefits for you or for your spouse or dependent family member, so it's no longer considered qualifying health coverage, and the date this coverage or benefits changed or will change.
☐ **22. Tax Season Easy Enrollment** Maryland **You must apply through your state's health benefit exchange.**	Your financial information has been validated by the Comptroller, and you don't need to send additional proof.
☐ **23. Easy Enrollment for Unemployment Insurance Claimants** Maryland **You must apply through your state's health benefit exchange.**	If you received a letter from Maryland Health Connection stating you preliminarily qualified for health care coverage. Your financial information has been validated by the Maryland Health Connection and you don't need to send additional proof.
☐ **24. Change in immigration status** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington† **You must apply through your state's health benefit exchange.**	☐ Official documentation of a change in citizenship or immigration status.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **25. Coverage as American Indian/Native Alaskan** California, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington† **You must apply through your state's health benefit exchange.**	☐ Official documentation showing your status.
Colorado	No proof required with your application.
☐ **26. Change in income changing your eligibility for federal financial assistance** California, Colorado†, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington† **You must apply through your state's health benefit exchange.**	**Provide one of these:** Proof of minimum essential coverage for all applicants from your prior carrier for at least one full day in the last 60 days. ☐ Paid premium invoice proving coverage within the last 60 days. ☐ Employer benefit record proving coverage within the last 60 days. **And provide:** ☐ Most recent eligibility determination from your state's health benefit exchange showing determination date.
☐ **27. Monthly Special Enrollment Period (SEP) for low-income subscribers** California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Virginia **You must apply through your state's health benefit exchange.**	If your income falls below 150% of the federal poverty level qualifying you for a monthly special enrollment period, no proof is required.
Washington	If your income falls below 250% of the federal poverty level, your state's exchange will determine if you qualify for a monthly special enrollment period and will let you know what, if any, proof is required.

†In this state, proof for qualifying life events is collected by Kaiser Permanente for health plans purchased on the exchange.

Primary applicant name

STEP 3: Proof of your qualifying life event *(continued)*

Qualifying life event	Type of proof
☐ **28. Tax Time Enrollment** Colorado	Your financial information has been validated through your tax filing and Connect for Health Colorado and you don't need to send additional proof.
☐ **29. Paid penalty for not having health coverage** California You must apply through your state's health benefit exchange.	If you paid the Individual Shared Responsibility Penalty to California's Franchise Tax Board within the last 60 days, no proof is required.
☐ **30. Being potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and being determined ineligible after open enrollment has ended or more than 60 days after the qualifying event** Maryland	☐ Letter or notice from Medicaid or Children's Health Insurance Program (CHIP), with date, stating that you are ineligible for coverage.

Submitting your proof

How are you applying?

- **If you're applying online:** Sign in at **kp.org/apply** and upload your proof. You don't need to upload this form.
- **If you're applying by mail or fax:** Use the information on this page to send your proof and this form to the address or fax number below.
- **If you're applying through the health benefit exchange:** The health benefit exchange may require submission of proof.

Send application or Account Change Form and proof along with this form:

By mail

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

By fax

1-855-355-5334

To download an Account Change Form, visit kp.org/specialenrollment.

By submitting a signed application or Account Change Form and proof of your qualifying life event, you're saying that the qualifying life event happened. It's important that we get proof of your qualifying life event. We will rely on your signature and proof to decide if you can enroll during a special enrollment period. If we determine that the qualifying life event didn't happen, or we learn of any other inaccuracy in the information that is included in the application, Account Change Form or any other information that you submit, we may take legal action. The legal action may include but is not limited to canceling your coverage retroactively to the day it started. You may also be responsible for the full charges of any services that you received.

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)**