KAISER PERMANENTE®

Individual and Family Plans

Account Change Form

Hawaii

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 HealthCare.gov, all account and plan changes to your existing coverage must be requested through HealthCare.gov. 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.

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

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 **1-800-966-5955** (TTY **711**).

- ☐ Change plans.
- ☐ Change my child-only account to a family account with myself as the subscriber.
- ☐ Add medical coverage for a family member.
- ☐ Add pediatric dental coverage (for members 18 and younger).

(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/are 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.)
- ☐ Someone on my account stopped using tobacco. (Please indicate which family member in Section C.)
- ☐ End pediatric dental coverage.

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 adult dental coverage ☐ End adultdental coverage

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 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 pediatric dental coverage ☐ End pediatric dental coverage

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 pediatric dental coverage ☐ End pediatric dental coverage

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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? *(continued)*

Dependent 3

☐ Name change ☐ Add medical coverage ☐ End medical coverage ☐ Add pediatric dental coverage ☐ End pediatric dental coverage

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☐ No

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 **1-800-255-5169** (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

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 the birth or placement of the child with you
- ☐ 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

Change in residence

- ☐ Permanent relocation with access to new plans

Other qualifying life events

- ☐ Determination by the health benefit exchange of exceptional circumstances

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.

- ☐ KP HI Bronze 6000/65
- ☐ KP HI Bronze 6000/65 Plus CAM
- ☐ KP HI Standard Bronze 7500/50
- ☐ KP HI Silver 3000 Ded/600 Rx Ded Off
- ☐ KP HI Silver 3000 Ded/600 Rx Ded Plus CAM Off
- ☐ KP HI Silver 4000 Ded/600 Rx Ded Off
- ☐ KP HI Standard Silver 6000/40 Off
- ☐ KP HI Gold 0/40
- ☐ KP HI Gold 0/40 Plus CAM
- ☐ KP HI Gold 1000 Ded/250 Rx Ded
- ☐ KP HI Standard Gold 2000/30
- ☐ KP HI Platinum 0/5
- ☐ KP HI Platinum 0/5 Plus CAM
- ☐ KP HI Standard Platinum 0/10

E. Choose your health plan *(continued)*

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. Required pediatric dental plan

If you enroll in a KPIF plan, by law you must also enroll in a separate pediatric dental plan. Or, if you already have other pediatric dental coverage that is certified by the health benefit exchange, you must let us know. The premium for pediatric dental coverage only applies to children 18 and younger. If you don't have pediatric dental coverage, we may cancel your health plan or take any other action permitted by law.

☐ I have bought separate pediatric dental coverage certified by the health benefit exchange for children 18 and younger.

G. Sign the form

- I understand that Kaiser Permanente for Individuals and Families (KPIF) will rely on the information I provide in this form, and that if any information is found to be fraudulent or intentionally misrepresented, Kaiser Permanente for Individuals and Families (KPIF) 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.
- 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 **kaiserpermanente.org/termsconditions**.

Note: The subscriber must sign the form. All new dependents 18 and older must also sign the form. If there are more than 3 dependents 18 and older 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) ☐☐/☐☐/☐☐☐☐
Dependent (18 and older)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐
Dependent (18 and older)

X _____ Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐
Dependent (18 and older)

All plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813.

H. Review the arbitration agreement

Kaiser Foundation Health Plan, Inc., Hawaii Market – Arbitration Agreement

Except as provided in the Dispute Resolution section of *Kaiser Permanente Hawaii's Guide to Your Health Plan* or by applicable law, any and all claims, disputes, or causes of action arising out of or related to your *Guide* or *Evidence of Coverage* (*EOC*), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs, or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the Member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this Agreement, all family members of the Member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;

On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers, or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders);
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed, and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

(continues on next page)

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, *9 U.S.C. Chapter 1*.

General Provisions

All claims based upon the same incident, transaction, or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

Arbitration confidentiality

Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

(continues on next page)

Review the arbitration agreement *(continued)*

Special Claims

Medical Malpractice Claims

Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initiating Arbitration" section.

Benefit Claims

If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at **1-800-966-5955** (TTY **711**).

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the "Dispute Resolution" section of your *Guide* or *EOC*.

External Appeal of Internal Review Decisions

If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this Agreement. In addition to the arbitration procedures set forth in this Agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of your *Guide* or *EOC*.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence, or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law, and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

I. Sign the Kaiser Foundation Health Plan, Inc., arbitration agreement

I acknowledge that I have read and understood the information and conditions set forth in the Arbitration provision located on pages 6, 7, and 8 in the Kaiser Foundation Health Plan, Inc. Hawaii Market Arbitration Agreement and agree that I, on behalf of myself, all applicants, and all family members, hereby agree to binding arbitration of all claims as described in that provision and agree we give up our constitutional rights to a jury or court trial with regard to such claims. By signing below, I understand that this action will serve as my signature of agreement to the conditions provided in the arbitration provisions in the Health Plan Agreement.

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) __ __ / __ __ / __ __ __ __

Dependent (18 and older)

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 **1-800-494-5314** (TTY **711**).

Contact information

Mail to: Kaiser Permanente P.O. Box 23127 San Diego, CA 92193	**Or fax to:** Membership Administration **1-855-355-5334**	**Questions? Call** **1-800-966-5955** (TTY **711**)

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex(including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at https://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice

---

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) PAGPAHIMANGNO: Kung nag-istorya ka og Cebuano, ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (Chinese) 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-966-5955**（TTY：**711**）。

Chuuk (Chukese) ESINESIN: Ika en mi sine Fosun Chuuk, mi kawor aninisin fosun fonu mei pachonong pisekin aninis, ese kamo, mi kawor ngonuk. Kekeri **1-800-966-5955** (TTY: **711**).

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke nā lawelawe kōkua ʻōlelo me nā kōkua kōkua kūpono a me nā lawelawe, manuahi ʻole, loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) ATENSION: No makasaoka iti Ilokano, dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-966-5955** (TTY: **711**)

日本語 (Japanese) 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-966-5955 までお電話ください（TTY：711）。**

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-966-5955** (TTY: **711**)로 전화해 주세요.

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-966-5955** (TTY: **711**).

Kajin Majōḷ (Marshallese) Roñjake: Ñe kwōjeḷā kajin Kajin Majōl, eo ej jipañ eok ilo kajin in ekaoba jerbal ko jet, ejjeḷọk oṇāāer, repeḷḷok ñan eok. Kūr tok **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien me kele mehlel oh sarawi kan me pahn limpoak, en kak sawa ni ke, lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) FA'AMALU: Afai e te tautala i le Gagana Samoa, o auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totogi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA: Kapau ʻoku ke lea Faka-Tonga, ʻoku ʻi ai ha sevesi tokoni fakatonu lea pea mo ha naunau meʼa fanongo, ʻoku taʼetotongi, mo faingamalie kiate koe. Taa **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-966-5955** (TTY: **711**).