KAISER PERMANENTE®

Application for health coverage

Individual and Family Plans

Who can use this application?

You may use this application to apply for individual or family coverage from Kaiser Permanente for Individuals and Families (KPIF).

- If you want coverage for your family on the same KPIF plan, please fill out 1 application for the family. If a family member wants a different health plan, he or she must complete a separate application.
- To be eligible for KPIF coverage, you must live in our California service area.
- If you qualify for and want to take advantage of federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You must apply for coverage through Covered California at coveredca.com.
- If you're already a member, don't use this form. To change your plan, call **1-866-410-7536.**

Things to remember

- You can apply faster online at **buykp.org/apply**.
- Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names.
- If we receive your completed application with payment by the 15th of the month and approve it, coverage will be effective on the 1st of the next month. If we receive your completed application with payment after the 15th and approve it, coverage will be effective on the 1st of the month after the next month.
- If you're applying during a special enrollment period, be sure to follow all the instructions in our Enrolling During a Special Enrollment Period guide and include any required documentation so your application will be complete. If you didn't receive this guide, you can find it at **buykp.org/apply**, or call **1-800-494-5314** to request a copy. Your application submission deadline and effective date may be different than the dates listed above if you apply during a special enrollment period.
- To avoid paying for 2 plans, if you are enrolled in another plan through Covered California or through Kaiser Permanente, you should end that plan before the start date of your new plan. To avoid a gap in coverage, be sure that plan ends the day before your new plan starts.
- **If your application is incomplete, not signed, doesn't include your first month's payment, or doesn't include required special enrollment period documentation, it may be canceled.**
- Send your complete, signed application and first month's premium payment by mail to:

  Kaiser Permanente for Individuals and Families
  P.O. Box 23219
  San Diego, CA 92193-9921

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

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

Need help?

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

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

Primary applicant

STEP 1: Tell us when you're applying

Select 1 option:

- ☐ Open enrollment
- ☐ A special enrollment period

If you're applying during a special enrollment period, please write the date of your triggering event.

Date (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

For more information on minimum essential coverage and qualifying triggering events, please refer to the Enrolling During a Special Enrollment Period guide. To request a copy, please call **1-800-494-5314.**

If you selected "A special enrollment period," choose the triggering event:

- ☐ Loss of health care coverage*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership registration
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, foster care, or placement for adoption or foster care (Please choose your effective date.)
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after gaining the dependent
- ☐ Losing a dependent through divorce, dissolution of domestic partnership, or legal separation
- ☐ Death of the subscriber or a dependent
- ☐ Child support order or other court order to cover a dependent
- ☐ Permanent relocation
- ☐ Release from incarceration
- ☐ Change in eligibility for federal financial assistance through Covered California†
- ☐ Change in eligibility for employer health coverage
- ☐ Determination by Covered California
- ☐ Misinformation about coverage
- ☐ Provider network changes

*If your triggering event is loss of Kaiser Permanente coverage, we may review your prior membership records to establish eligibility.
†If you'll be getting federal financial assistance, don't use this form. We can help you apply at coveredca.com.

STEP 2: Choose your health plan

Choose 1 health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze

- ☐ Kaiser Permanente – Bronze 60 HDHP HMO 5500/40%
- ☐ Kaiser Permanente – Bronze 60 HMO
- ☐ Kaiser Permanente – Bronze 60 HDHP HMO

Silver

- ☐ Kaiser Permanente – Silver 70 HMO
- ☐ Kaiser Permanente – Silver 70 HMO 1750/40
- ☐ Kaiser Permanente – Silver 70 HDHP HMO 2700/15%

Gold

- ☐ Kaiser Permanente – Gold 80 HMO
- ☐ Kaiser Permanente – Gold 80 HMO Coinsurance

Platinum

- ☐ Kaiser Permanente – Platinum 90 HMO

Minimum coverage plan

To purchase a minimum coverage plan, applicants must be younger than 30 on the effective date, or provide a certificate of exemption from Covered California 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 **marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf** and follow the instructions.

- ☐ Kaiser Permanente – Minimum Coverage HMO

For information about health and dental benefits and limitations, cost-sharing amounts, and premiums, please review the details in your enrollment materials. To request a copy of the *Membership Agreement, Disclosure Form, and Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-800-634-4579,** or contact your broker.

STEP 3: Choose your optional dental plan

Dental coverage is included in your health plan for child members until the end of the month in which the member turns 19. Kaiser Permanente offers an optional dental insurance plan to adults, which includes those individuals whose eligibility for pediatric dental services has ended. This optional coverage is available for an additional charge. Our optional adult dental coverage is underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP), and administered by Delta Dental of California, one of the nation's largest and most experienced dental benefits providers. Please choose 1 option below.

- ☐ Yes, I agree to enroll in the KPIC dental insurance plan. Kaiser Permanente Insurance Company, a subsidiary of Kaiser Foundation Health Plan, Inc., underwrites the dental insurance plan. Once enrolled, you can't cancel your dental coverage without canceling your regular health coverage, unless you make the change during open enrollment or a special enrollment period.
- ☐ No. I'm not interested in optional dental coverage.

STEP 4: Enter your information

Primary applicant

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

First name

Social Security number (if you have one)

Last name

Phone

MI

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

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

City

State

ZIP code

County

Mailing address (if different than home address)

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email address (optional) *I understand that Kaiser Permanente may contact me via email.*

Spouse/domestic partner to be covered

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

First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Parent or legal guardian

(if the primary applicant is a child under 18)

First name

MI

Last name

Social Security number (if you have one)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Preferred language spoken (if not English)

Preferred language read (if not English)

(continues)

Primary applicant

STEP 4: Enter your information *(continued)*

Dependents to be covered

If you have more than 4 dependents to be covered, attach another application and complete just the information for those applicants.

1 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

2 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

3 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

4 First name

MI

Last name

Social Security number (if you have one)

Former medical record number (if any)

Home state (if any)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy)

Relationship to primary applicant

Primary applicant

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

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

First name

MI

Last name

Phone

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

X

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

Date (mm/dd/yyyy)

STEP 6: Sign the application agreement

Important: All applicants and dependents 18 and older must read, sign, and date below. If the primary applicant is a child under 18, then his or her parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If signatures are missing, we will cancel the application.

- I understand that Kaiser Foundation Health Plan, Inc., will rely on the information provided in this application. If any information is found to be fraudulent or intentionally misrepresented, then Kaiser Foundation Health Plan, Inc., may choose to terminate coverage back to the coverage effective date.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.

X

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

Date (mm/dd/yyyy)

X

Spouse/domestic partner

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

X

Dependent (18 and older)

Date (mm/dd/yyyy)

Primary applicant

STEP 7: Sign the Kaiser Foundation Health Plan 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 *Membership Agreement, Disclosure Form, and Evidence of Coverage*.

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)

Primary applicant

STEP 8: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Amount for your first month's premium

$, .

Address

City

State

ZIP code

Payment options

☐ **Credit card** ☐ **Debit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

/

X

Date (mm/dd/yyyy)

/ /

Cardholder's signature

☐ **Electronic payment** ☐ Checking account ☐ Savings account

I authorize Kaiser Foundation Health Plan, Inc., and the designated financial institution to accept this transfer from my checking or savings account when my application is processed by KFHP.

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Date (mm/dd/yyyy)

/ /

Account holder's signature

☐ **Check** ☐ **Money order**

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

Primary applicant

Automatic monthly payments

This **optional** service allows you to automatically pay your monthly premiums electronically. If you'd like to sign up, please fill out your information below. To cancel or update automatic payments, go to **kp.org/payonline** or call the Member Service Contact Center at **1-800-464-4000.**

Billing information

Is this information the same as your first month's payment details? ☐ Yes ☐ No **If no, please fill out this section.**

First name of person responsible for payment

MI

Last name of person responsible for payment

Billing address

City

State

ZIP code

Payment options

Debit cards can't be used for automatic monthly payments.

☐ **Credit card** ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

X

Cardholder's signature

Date (mm/dd/yyyy)

☐ **Electronic payment** ☐ Checking account ☐ Savings account

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

Bank name

Routing number

Account number

Account holder's first name

MI

Account holder's last name

X

Account holder's signature

Date (mm/dd/yyyy)

Primary applicant

For applicants using an Agent/Broker/KPIF representative

If you used an agent/broker/KPIF representative, please make sure he or she completes this page. A Kaiser Permanente representative includes any agent/broker/KPIF representative who has helped you decide which plan to enroll in or helped you fill out the application.

Agent/Broker/KPIF representative first name

MI

Last name

The broker of record may receive monetary and/or nonmonetary payments from KPIF in connection with the purchase of this coverage.
Note: Premiums are the same whether or not you use an agent/broker/KPIF representative.

To be completed by your Kaiser Permanente–appointed agent/broker/KPIF representative after completion of this application:

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

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

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

☐ Yes ☐ No

X

Agent/Broker/KPIF representative

Date (mm/dd/yyyy)

Agent/Broker/KPIF representative (first, middle, last) (please print)

Address

City

State

ZIP code

KPIF–appointed broker ID number

Phone

Fax

Email address

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html.***

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), Medi-Cal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles, en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en ***http://www.hhs.gov/ocr/office/file/index.html*.**

Kaiser Permanente禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計畫成員服務聯絡中心提供語言協助服務；每週七天24小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以便您使用本機構的設施與服務 。此外，您還可請求以您的語言提供健康保險計畫資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電**1-800-757-7585**（TTY專線使用者請撥**711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用爭議解決方案，請參閱您的:《保險計畫承保項目說明書》或《保險證明書》，或者與計畫成員服務代表交談。對於Medicare、Medi-Cal、MRMIP、Medi-Cal Access、FEHBP或CalPERS計畫成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：
於設在本計畫服務設施的某個計畫成員服務處填妥一份《投訴或保險福利索償/請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）

- 將您的冤情申訴書郵寄至設在本計畫服務設施的某個計畫成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 致電本機構的計畫成員服務聯絡中心，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）
- 在本機構的網站上填妥一份冤情申訴書，網址是 **kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計畫成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給Kaiser Permanente的民權事務協調員。您也可與Kaiser Permanente的民權服務協調員直接聯絡；聯絡地址是One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以採用電子方式透過民權辦公處的投訴入口網站向美國衛生與公共服務部民權辦公處提出民權投訴，網址是*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*； 或者按照如下聯絡資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD專線)。可從網站上下載投訴書，網址是***http://www.hhs.gov/ocr/office/file/index.html***。

Language Assistance Services

English: We provide interpreter services at no cost to you, 24 hours a day, 7 days a week, during all hours of operation. You can have an interpreter help answer your questions about our health care coverage. You can also request materials translated in your language at no cost to you. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: نؤمن خدمات الترجمة الفورية مجانًا لك على مدار الساعة كافة أيام الأسبوع طوال ساعات العمل. بإمكانك طلب مساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التغطية الصحية التي نقدمها. بالإضافة إلى ذلك، يمكنك طلب ترجمة الوثائق الطبية للغتك مجانًا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Մենք օրը 24 ժամ, շաբաթը 7 օր, մեր աշխատանքի բոլոր ժամերին Ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ ենք տրամադրում: Թարգմանչի օգնությամբ Դուք կարող եք պատասխան ստանալ Ձեր հարցերին՝ մեր կողմից տրամադրվող առողջության ապահովագրության վերաբերյալ: Կարող եք նաև Ձեր լեզվով թարգմանված գրավոր նյութեր խնդրել, որոնք Ձեզ համար անվճար են: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711** համարով:

Farsi: ما خدمات مترجم شفاهی را در 24 ساعت شبانروز و 7 روز هفته در طول همه ساعات کاری بدون اخذ هزینه در اختیار شما قرار می دهیم. شما می توانید برای کمک در پاسخگویی به سؤالات خود در مورد پوشش مراقبت درمانی ما از یک مترجم شفاهی بهره مند شوید. همچنین می توانید درخواست کنید که همه جزوات بدون اخذ هزینه به زبان شما ترجمه شوند. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند

Hindi: हम संचालन के सभी घंटों के दौरान आपको बिना किसी लागत के दुभाषिया सेवाएँ**24** दिन के , घंटेसप्ताह के , सातों दिन प्रदान करते हैं। आप हमारी स्वास्थ्य देखभाल कवरेज के बारे में आपके प्रश्नों के जवाब के लिए एक दुभाषिये की सहायता ले सकते हैं। आप बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए अनुरोध भी कर सकते हैं। बस केवल हमें **1-800-464-4000** पर**24** दिन के , घंटे , कॉल करें। (छुट्टियों वाले दिन बंद रहता है) सप्ताह के सातों दिन **TTY** उपयोगकर्ता **711**पर कॉल करें।

Hmong: Peb muaj neeg txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg, thawm cov sij hawm qhib ua lag luam.Koj muaj tau ib tug neeg txhais lus los pab teb koj cov lus nug txog peb cov kev pab them nqi kho mob.Koj thov tau kom muab cov ntaub ntawv txhais uas koj hom lus pub dawb rau koj.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、全診療時間を通じて、 通訳サービスを無料で、年中無休、終日ご利用いただけます。当院の医療内容についてのご質問および回答には、 通訳がお手伝いいたします。 また、日本語に翻訳された資料を無料で請求できます。お気軽に **1-800-464-4000** までお電話ください （祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: យើងផ្តល់សេវានៃអ្នកបកប្រែ ដោយឥតអស់ថ្លៃ ដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ ក្នុងអំឡុង ម៉ោងធ្វើការទាំងអស់។ អ្នកអាចមានអ្នកបកប្រែ ដើម្បីជួយ ឆ្លើយសំណួររបស់អ្នក អំពីការរ៉ាប់រងថែទាំសុខភាព របស់ យើង។ អ្នកក៏អាចស្នើសុំសំភារៈដែលបានបកប្រែជាភាសា ខ្មែរ ដោយឥតអស់ថ្លៃដល់អ្នកដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយ អាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711** ។

Korean: 업무 시간 동안에는 요일 및 시간에 관계없이 통역 서비스를 무료로 이용하실 수 있습니다. 통역의도움을받아 건강 보험 혜택에 관하여 질문하고 답변을 들으실 수 있습니다. 또한, 귀하가 사용하는 언어로 번역된 자료를 요청해 무료로 제공받으실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화해 문의하십시오(공휴일 휴무). TTY 사용자 번호 **711**.

Navajo: Nihí ata' halne'é áká'adoolwołígíí nihei hóló t'áá jíík'é, t'áá naadiin dį́į' ahéé'iilkeedgo, tsosts'id yiskąąjį', ndá'anishgo oolkił biyi' góné. Ata' halne'é niká'adoolwoł na'ídikid nee hóló́ógo díí ats'íis baa áháyą́ą bik'éstí'ígíí biná'ídiłkidgo. Áádóó ałdó' naaltsoos lá t'áá ní nizaad k'ehji álnéehgo t'áá jíík'é ádoolníił. Nihích'i' hodíilnih koji' **1-800-464-4000** jį́igo dóó tł'ée' nidi, tsosts'id yiskąąjį' dimoo na'adleehjį' (Holidaysgo éí da'deelkaal) doo da'diits'a'ígíí chodayooł'į́nígíí koji' hodíilnih **711**

Punjabi: ਅਸੀਂ ਕਾਰਵਾਈ ਦੇ ਸਾਰੇ ਘੰਟਿਆਂ ਦੇ ਦੌਰਾਨਤੁਹਾਨੂੰ ਬਿਨਾਂ , 24 ਦਿਨ ਦੇ ,ਕਿਸੀ ਲਾਗਤ ਦੇਘੰਟੇ 7 ਹਫਤੇ ਦੇ ,ਦਿਨਦੁਭਾਸ਼ੀਆ , ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਵਰੇਜ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ 24 ਦਿਨ ਦੇ ,ਘੰਟੇ7 ਹਫ਼ਤੇ ਦੇ , ਦਿਨ ਛੁੱਟੀਆਂ) ਵਾਲੇ ਦਿ◌ਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈਫ਼ੋਨ ਕਰੋ (।TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711**ਤੇ ਫ਼ੋਨ ਕਰਨ।'

Russian: Мы всегда в часы работы обеспечиваем Вас услугами устного переводчика, 24 часа в сутки, 7 дней в неделю. Чтобы получить ответы на свои вопросы о нашем страховом покрытии услуг здравоохранения, Вы можете воспользоваться помощью устного переводчика. Вы также можете запросить бесплатный перевод материалов на Ваш язык. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Ofrecemos servicios de traducción al español sin costo alguno para usted durante todo el horario de atención, 24 horas al día, siete días a la semana. Puede contar con la ayuda de un intérprete para responder las preguntas que tenga sobre nuestra cobertura de atención médica. Además, puede solicitar que los materiales se traduzcan a su idioma sin costo alguno. Solo llame al **1-800-788-0616**, 24 horas al día, siete días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na mga serbisyo ng tagasalin ng wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo, sa lahat oras ng trabaho. Makakatulong ang tagasalin ng wika sa pagsagot sa mga tanong mo tungkol sa iyong coverage sa pangangalagang pangkalusugan. Maaari kang humingi ng mga babasahin na isinalin sa iyong wika nang wala kang babayaran. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 **ชั่วโมงทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Chinese: 我們每週 7 天，每天 24 小時在所有營業時間內免費爲您提供口譯服務。您可以請口譯員協助回答有關我們健康保險的問題。您也可以免費索取翻譯成您所用語言的資料。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần, trong tất cả các giờ làm việc. Quý vị có thể được thông dịch viên giúp trả lời thắc mắc về quyền lợi bảo hiểm sức khỏe của chúng tôi. Quý vị cũng có thể yêu cầu được cấp miễn phí tài liệu phiên dịch ra ngôn ngữ của quý vị. Chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.