Special enrollment period guide and form

What is the special enrollment period?

In general, you can only change or apply for health care coverage and the Kaiser Permanente Charitable Health Coverage Program during the yearly open enrollment period. But if you have a certain type of event in your life, called a qualifying life event, you can change or apply for coverage for a limited period of time after that event. This is called a special enrollment period.

How long does the special enrollment period last?

The special enrollment period generally lasts 60 days from the date of your qualifying life event. For example, if you have a baby on June 1, you have 60 days — or by July 30 — to apply for coverage.

Who should use this form?

Use this form if you have had a qualifying life event and are applying for Kaiser Permanente's Charitable Health Coverage Program (CHC) during a special enrollment period.

You also need to complete an Application for Health Coverage and the Subsidy Eligibility Form.

Charitable Health Coverage program names vary by region:

- Northern California: Community Health Care Program
- Southern California: Child Health Program
- Colorado: Colorado Bridge Program
- Georgia: Georgia Bridge Program; Note: You must be actively enrolled in a training program with a participating community partner.
- Maryland and Virginia: Community Health Access Program
- Oregon: Child Health Program Plus; Note: You can apply for the Child Health Program Plus anytime through an approved Community Partner; you do not need to use this form.

Kaiser Permanente CHC members who just want to add an eligible family member to their account should not use this form.

Use the CHC Account Change Form instead. Contact us at the phone number listed on page 2 to obtain a CHC Account Change Form or visit **kp.org/chcspecialenrollment**.

What are the qualifying life events?

Here's a list of some of the life events that could qualify you for a special enrollment period:

- Loss of health care coverage
- Gaining, becoming, or losing a dependent
- Child support order or other court order to cover a dependent (varies by state)
- Permanently relocating (moving)
- Change in eligibility for federal financial assistance through the health insurance marketplace
- Change in eligibility for employer health coverage
- Determination by the health insurance marketplace

There are more events if you:

- Get your health coverage through the marketplace:
  - Change in immigration status
  - Coverage as an American Indian/ Native Alaskan
- Live in California:
  - Misinformation about your current coverage
  - Provider network changes
- Live in Colorado:
  - Contract violation

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Some qualifying life events require that you had prior health coverage to qualify for a special enrollment period. For more information on qualifying life events and start dates and prior coverage requirements, visit **kp.org/chcspecialenrollment**.

Eligibility rules for Kaiser Permanente's Charitable Health Coverage Program still apply during the special enrollment period. Even if you have a qualifying life event, you still have to be eligible for CHC. To view eligibility requirements for CHC in your region, go to **kp.org/chcspecialenrollment**.

What if my qualifying life event happens during open enrollment?

Even if your qualifying life event happens during open enrollment, you'll still have a special enrollment period.

What if I know about my qualifying life event in advance?

If your qualifying life event is a loss of coverage that you know about in advance, you may be able to apply for new coverage ahead of time. In this case, you may have 60 days before and 60 days after the event to apply.

How do I apply?

If you have had a qualifying life event and are applying for Kaiser Permanente's Charitable Health Coverage Program during a special enrollment period, please complete these steps:

- Fill out Steps 1, 2, and 3 of this **Special Enrollment Period Form,** starting on page 3.
- Provide proof of your qualifying life event following the instructions in Step 3.
- Fill out the additional required forms:
  - **Application for Health Coverage:** In Colorado, use the DORA form. In other regions, use the Kaiser Permanente Individual and Families Application.
  - **CHC Subsidy Eligibility Form:** Include proof of income with this form.
  - You can find these forms at **kp.org/chcspecialenrollment.**

Where to submit your forms and proof

Send your Special Enrollment Period Form and proof of qualifying life event along with your Application for Health Coverage, Subsidy Eligibility Form and proof of income:

By mail
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 939095
San Diego, CA 92193-9095

By fax
1-858-614-3344

When to submit your forms and proof

Submit your forms, proof of income and proof of qualifying life event before your special enrollment period ends. The special enrollment period generally lasts 60 days from the date of your qualifying life event.

If we don't get your proof in time, we'll have to cancel your application. You may apply again if you're still within your special enrollment period.

Need help?

Visit **kp.org/chcspecialenrollment** for more information. You can also call:

Northern California **1-800-464-4000**
Southern California **1-800-464-4000**

Colorado
- Southern Colorado **1-888-681-7878**
- Denver/Boulder **303-338-3800**
- Northern CO **1-844-201-5824**
- Mountain CO **1-844-837-6884**

Georgia **1-888-865-5813**
Maryland and Virginia **1-800-777-7902**
TTY for all states **711**

Primary applicant name

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STEP 1: Primary applicant information

Who is the primary applicant?

- The primary applicant is the person who'll be covered by the health plan.
- If the application is only for a child under 18, the child is the primary applicant.

Please note: This isn't an application for the Charitable Health Coverage (CHC) Program. To get health care coverage through CHC, you need to submit an application for health coverage (In Colorado, use the DORA form. In all other regions, use the Kaiser Permanente Application for Health Coverage.) and Subsidy Eligibility Form to see if you qualify for the program.

First name

Social Security number (if any) ___ - ___ - ____

Last name

Phone ___ - ___ - ____

MI

Application ID number (if you applied online)

Gender: ☐ Male ☐ Female

Date of birth (mm/dd/yyyy) __ / __ / ____

Health/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

Primary applicant name

STEP 2: Qualifying life event information

Qualifying life event number from Step 3

Date of qualifying life event (mm/dd/yyyy)

For loss of health care coverage, the date of the qualifying life event is the last full day you were covered under your old plan.

STEP 3: Proof of your qualifying life event

Instructions:

- Check 1 box for your qualifying life event and 1 box for the proof you're sending in (unless otherwise noted). Make sure the qualifying life event and the type of proof apply to your state.
- Send in 1 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
  - Health/medical record number (if any)
  - Home address (no P.O. boxes)
  - Date of birth

Qualifying life event By State	**Type of proof**
☐ **1. Loss of health care coverage** California, Colorado, Georgia, Maryland Keep in mind, this event does NOT qualify as 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 do not have any other coverage. • Youvoluntarily ended your coverage.	**Letter from your employer** ☐ Letter or other document from your employer stating that the employer dropped or will drop coverage or benefits for you, your spouse, or dependent family member and the date when this coverage ended or will end. ☐ Letter or document from your employer stating that the employer stopped or will stop contributing to the cost of coverage and the date when this contribution ended or will end. ☐ Letter showing your employer's offer of COBRA coverage or stating when your COBRA coverage ended or will end. **Letter from your insurer or Medicaid, Medi-Cal, Medicare, or other government programs** ☐ Letter from your health insurance company showing a coverage end date, including a COBRA coverage end date. ☐ Letter from school stating when student health coverage ended or will end. ☐ 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.

(continues)

Primary applicant name

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

Qualifying life event By State	Type of proof
1. Loss of health care coverage *(continued)* California, Colorado, Georgia, Maryland	**Other** ☐ Dated military discharge papers or Certificate of Release, including the date that 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 an agent/broker/producer or dated letter from the insurer, if you are or were enrolled in a non-calendar year plan that's ending, including the date the plan ended. ☐ Pay stubs of both current and previous hours if a reduction in work hours caused you to lose coverage.
☐ **2. Gaining or becoming a dependent through marriage (or domestic partnership/civil union). Check 2 boxes total.** California, Colorado, Georgia, Maryland, Virginia	**Provide this:** ☐ Proof of minimum essential coverage in the last 60 days from your insurer (applicants moving within the U.S. only). **And provide 1 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.
California, Colorado	☐ Proof of minimum essential coverage in the last 60 days from your insurer (applicants moving within the U.S. only). **And provide:** ☐ Official government record, including date of domestic partnership or civil union registration.
☐ **3. Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care** California, Colorado, Georgia, Maryland, Virginia	**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 health insurance company, 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. ☐ 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 filing date stamp. ☐ Foster care papers dated and signed by a court official.

Primary applicant name

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

Qualifying life event By State	Type of proof
☐ **4. Child support order or other court order to cover a child** Georgia, Maryland, Virginia **Child support order or other court order to cover a dependent** California, Colorado	☐ Signed court order with court filing date stamp.
☐ **5. Permanent relocation** California, Colorado, Georgia, Maryland, Virginia **In this instance, you move from a non–Kaiser Permanente service area to a Kaiser Permanente service area, or you move from a foreign country or a United States territory.**	**Provide this:** ☐ Proof of minimum essential coverage from your insurer for at least 1 full day in the last 60 days (applicants moving within the U.S. only). **And provide any of these: 1 with your old residential address and 1 with your new residential 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 that 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. ☐ Naturalization papers signed and dated within the last 60 days or green card, Education Certificate, or visa (if you moved to the U.S. from another country).

Primary applicant name

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

Qualifying life event By State	Type of proof
☐ **6. Release from incarceration** California	☐ 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.
☐ **7. Determination by the health insurance marketplace** California, Colorado, Georgia, Maryland, Virginia	☐ Letter or notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
☐ **8. Contract violation** Colorado	☐ Written confirmation, with date, from the Division of Insurance that the health plan in which you're enrolled has substantially violated a material provision of your contract.
☐ **9. Misinformation about coverage** California	☐ Notice from the marketplace stating you're eligible for a special enrollment period and showing determination date.
☐ **10. Provider network changes** California	☐ Notice from provider stating you're eligible for a special enrollment period and showing determination date.
☐ **11. 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.
☐ **12. Death of the subscriber or dependent** California, Maryland	☐ Death certificate.

Primary applicant name

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

Qualifying life event By State	Type of proof
☐ **13. Change in eligibility for federal financial assistance through the health insurance marketplace** California, Colorado, Georgia, Maryland	☐ Most recent eligibility determination from the marketplace showing determination date.
☐ **14. Change in eligibility for employer health coverage** California, Colorado, Georgia, Maryland	☐ Letter from employer stating change in minimum essential health coverage and showing determination date. ☐ Letter or other document from your employer stating that 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 when this coverage or benefits changed or will change.
☐ **15. Enrollment in Charitable Health Coverage Program though a Community Partner** Georgia	☐ Letter from Community Partner verifying enrollment.

By submitting a signed application, Subsidy Eligibility 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 decide that the qualifying life event didn't happen, 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 cost of any services that you got.

In California, KFHP plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612 • In Colorado, all plans are offered and underwritten by Kaiser Foundation Health Plan of Colorado, 10350 E. Dakota Ave., Denver, CO 80247 • In Georgia, all plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Rd. NE, Atlanta, GA 30305 • In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852.

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 disputeresolution options that apply to you. This is especially important if you are a Medicare, MediCal, MRMIP, MediCal Access, FEHBP, or CalPERS member because you have different disputeresolution 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 *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 ***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, MediCal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), MediCal 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 (Office for Civil Rights), en ***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 ***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。

計劃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劃資料之譯本，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《*承保範圍說明書*》（*Evidence of Coverage*）或《*保險證明書*》（*Certificate of Insurance*），或者與計劃成員服務代表交談。對於Medicare、MediCal、MRMIP、MediCal Access、FEHBP或CalPERS計劃成員，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：

- 於設在本計劃服務設施的某個計劃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劃服務設施的某個計劃成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 免費致電本機構的計劃成員服務聯絡中心，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，請致電本機構的計劃成員服務聯絡中心。

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（Civil Rights Coordinator）。您也可與Kaiser Permanente的民權事務協調員直接聯絡；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（Office for Civil Rights）的投訴入口網站（Civil Rights Complaint Portal）向美國衛生與公共服務部民權辦公處（U.S. Department of Health and Human Services, Office for Civil Rights）提出民權投訴，網址是***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***www.hhs.gov/ocr/office/file/index.html***。

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, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **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. 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: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: 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**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。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**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. 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: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub 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.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、言語支援を無料で、年中無休、終日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、あるいは資料を別の書式でも依頼できます。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: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកទូរស័ព្ទ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរសព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Navajo: Saad bee áká’a’ayeed náhólǫ́ t’áá jiik’é, naadiin doo bibąą’ díí’ ahéé’iikeed tsosts’id yiskąąjí damoo ná’ádleehjí. Atah halne’é áká’adoolwołígíí jóki, t’áadoo le’é t’áá hóhazaadjí hadilyąą’go, éí doodaii’ náánáá lá ał’ąą ádaat’ehígíí bee hádadilyaa’go. Kojí hodiilnih **1-800-464-4000**, naadiin doo bibąą’ díí’ ahéé’iikeed tsosts’id yiskąąjí damoo ná’ádleehjí [Dahodiyin biniiyé e’e’aahgo éí da’deelkaalÓ. TTY chodeeyoolínígíí kojí hodiilnih **711**

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. 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: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. 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 **ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่าม ช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปล เอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการ เพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch 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, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. 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**.