KAISER PERMANENTE®

2026 Member Handbook Errata

This is important information about changes to your 2026 Kaiser Foundation Health Plan, Inc. Medi-Cal Member Handbook

Your Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form ("EOC/DF"). This Errata lets you know about updates to your 2026 Member Handbook. Please keep this document with your 2026 Member Handbook.

In this Member Handbook Errata, Kaiser Foundation Health Plan, Inc. is sometimes referred to as "we", "our," or "us." Members are sometimes called "you". Some capitalized words have special meaning in this Member Handbook. See Chapter 8, "Important numbers and words to know", of the Member Handbook for terms you should know.

Changes to the benefits are underlined below.

Revised description under "Pre-approval (Prior Authorization" in Chapter 3 (How to get care)

Pre-approval (prior authorization)

Prior authorization in Northern California

For the services listed under the heading "Services that need Pre-Approval (Prior Authorization)" later in this chapter, your PCP or specialist will need to ask the Permanente Medical Group for permission before you get the care. This is called asking for pre-approval or prior authorization. It means the Permanente Medical Group must

make sure the care is medically necessary (needed).

Medically necessary services are services that are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under age 21, Medically necessary services include care that is medically necessary to fix or help relieve a physical or mental illness or condition.

For standard pre-approval (prior authorization) requests, the Permanente Medical Group must respond to your request as soon as your health condition requires, but no more than five business days from when [they] get the information it asked for that it reasonably need to decide (approve, change, or deny) your request. The Permanente Medical Group must respond, no more than seven calendar days from when they get your request.

For requests in which a provider indicates, or the applicable The Permanente Medical Group designee determines that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, the Permanente Medical Group will make a faster expedited pre-approval (prior authorization) decision. The Permanente Medical Group will respond as soon as your health condition requires, but no longer than 72 hours from when they get your request.

In certain cases, the Permanente Medical Group may need more information to decide (approve, change, or deny) your pre-approval (prior authorization) request. If this happens, the Permanente Medical Group has up to 14 more calendar days to decide. Once the Permanente Medical Group gets the needed information, it must make a decision as soon as your health condition requires, but no later than five business days for standard requests or 72 hours for expedited requests.

Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

We do not influence the reviewers' decision to deny, change, or approve coverage or services in any way. If the Permanente Medical Group does not approve the request, we will send you a Notice of Action (NOA) letter. The NOA will tell you how to file an appeal if you do not agree with the decision.

We will contact you if the Permanente Medical Group needs more information or more time to review your request.

Prior authorization in Southern California

For the services listed under the heading "Services that need Pre-Approval (Prior

Authorization)" later in this chapter, your PCP or specialist will need to ask the Southern California Permanente Medical Group for permission before you get the care. This is called asking for pre-approval or prior authorization. It means the Southern California Permanente Medical Group must make sure the care is medically necessary (needed).

Medically necessary services are services that are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under age 21, Medically necessary services include care that is medically necessary to fix or help relieve a physical or mental illness or condition.

For standard pre-approval (prior authorization) requests, the Southern California Permanente Medical Group must respond to your request as soon as your health condition requires, but no more than five business days from when they get the information it asked for that it reasonably need to decide (approve, change, or deny) your request. The Southern California Permanente Medical Group must respond, no more than seven calendar days from when [they] get your request.

For requests in which a provider indicates, or the applicable Southern California Permanente Medical Group designee determines that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, the Southern California Permanente Medical Group will make a faster expedited pre-approval (prior authorization) decision. The Southern California Permanente Medical Group will respond as soon as your health condition requires, but no longer than 72 hours from when they get your request.

In certain cases, the Southern California Permanente Medical Group may need more information to decide (approve, change, or deny) your pre-approval (prior authorization) request. If this happens, the Southern California Permanente Medical Group has up to 14 more calendar days to decide. Once the Southern California Permanente Medical Group gets the needed information, it must make a decision as soon as your health condition requires, but no later than five business days for standard requests or 72 hours for expedited requests.

Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

We do not influence the reviewers' decision to deny, change, or approve coverage or services in any way. If the Southern California Permanente Medical Group does not approve the request, we will send you a Notice of Action (NOA) letter. The NOA will tell

you how to file an appeal if you do not agree with the decision.

We will contact you if the Southern California Permanente Medical Group needs more information or more time to review your request.

Services that need Pre-Approval (Prior authorization)

The following are examples of services that always need pre-approval:

- Acupuncture services when you need more than two visits per month
- Community-Based Adult Services (“CBAS”)
- Dental anesthesia
- Durable medical equipment
- Home health care
- Ostomy and urological supplies
- Prosthetics and orthotics
- Services not available from Medi-Cal Network Providers
- Transplants
- Medical Transportation when it is not an emergency

Emergency Care, including emergency ambulance services, does not require pre-approval (prior authorization).

You never need pre-approval (prior authorization) for emergency care, even if it is out of the Kaiser Permanente Medical network or outside your Home Region service area. This includes labor and delivery if you are pregnant. You do not need pre-approval (prior authorization) for certain sensitive care services. To learn more about sensitive care services, read “Sensitive care” later in this chapter.

For the complete list of services that require pre-approval and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call Member Services at **1-855-839-7613** (TTY **711**).

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you might want a second opinion if you want to make sure your diagnosis is correct, you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan, and it has not worked.

We will pay for a second opinion if your Medi-Cal network provider asks for it, and you get the second opinion from a Medi-Cal network provider. You do not need permission from us to get a second opinion from a Medi-Cal network provider. Your Medi-Cal network provider can help you get a referral for a second opinion if needed.

To get a second opinion call your PCP. Your PCP can refer you to a Medi-Cal network provider who is an appropriately qualified medical professional for your medical condition for a second opinion, call our Member Services at **1-855-839-7613** (TTY **711**) to help you get a referral for a second opinion if you want one.

If there is no qualified Medi-Cal network provider to give you a second opinion, our Member Services will help you get an opinion from an out-of-network provider. If we refer you to an out-of-network provider for a second opinion, we will pay for the second opinion. We will tell you if the provider you choose for a second opinion is approved as fast as your medical condition requires, but no more than five business days from when the Plan gets the information it asked for that it reasonably needs to decide your request, we must respond no more than seven calendar days from when we get your request.

If you have a chronic, severe, or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, we will tell you in writing within 72 hours of getting your request.

If we deny your request for a second opinion, you can file a grievance. To learn more about grievances, read “Complaints” in Chapter 6, “Reporting and solving problems” of the Member handbook.

Revised description under “Other Medi-Cal programs and services not covered by Kaiser Permanente” in Chapter 4 (Benefits and services)

Kaiser Permanente does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. We will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not by us. This section lists some of these services. To learn more, call our Member Services at **1-855-839-7613** (TTY **711**).

Dental Managed Care in Sacramento and Los Angeles Counties

Medi-Cal Dental Managed Care Program uses managed care plans to provide your dental services. You must enroll in Dental Managed Care. In some cases, you may qualify for an exemption from enrolling in Dental Managed Care. To learn more, go to Health Care Options at: http://dhcs.ca.goc/mymedi-cal. You can also call Health Care Options at **1 800-430-4263.**

Note: Anesthesia services for certain dental procedures are covered under the terms of this Member Handbook. See the “Anesthesiologist services” heading under “Outpatient Care” in Chapter 4, “Benefits and services”, of this Member Handbook for more information.

Dental services in other counties

Medi-Cal Dental FFS is the same as Medi-Cal FFS for your dental services. Before you get dental services, you must show your Medi-Cal BIC card to the dental provider. Make sure the provider takes Dental FFS and you are not part of a managed care plan that covers dental services.

Medi-Cal covers a broad range of dental services through Medi-Cal Dental including:

- Complete and partial dentures
- Crowns (prefabricated/laboratory)
- Diagnostic and preventive dental services such as examinations, X-rays, and teeth cleanings
- Emergency care for pain control
- Fillings
- Orthodontics for children who qualify
- Root canal treatments (anterior/posterior)
- Scaling and root planing
- Tooth extractions
- Topical fluoride

If you have questions or want to learn more about dental services, call Medi-Cal Dental at **1-800-322-6384** (TTY **1-800-735-2922** or **711**). You can also go to the Medi-Cal Dental website at https://www.dental.dhcs.ca.gov.

Revised description under “Other services children can get through Fee-for-Service (FFS) Medi-Cal or Other programs ” in Chapter 5 (Child and youth Well care)

Child and youth members under 21 years old can get needed health care services as soon as they are enrolled. This makes sure they get the right preventive, dental, and mental health care, including developmental and specialty services. This chapter explains these services.

Other services children can get through Fee-for-Service (FFS) Medi-Cal or other programs

Dental check-ups

Keep your baby’s gums clean by gently wiping the gums with a washcloth every day. At about four to six months, “teething” will begin as the baby’s teeth start to come in. You should make an appointment for your child’s first dental visit as soon as their first tooth comes in or by their first birthday, whichever comes first.

These Medi-Cal dental services are free services for:

Babies age 0-3

- Baby’s first dental visit
- Baby’s first dental exam
- Dental exams (every six months, and sometimes more)
- X-rays
- Teeth cleaning (every six months, and sometimes more)
- Fluoride varnish (every six months, and sometimes more)
- Fillings
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Kids age 4-12

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Molar sealants
- Fillings
- Root canals
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Youths age 13 -20

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Partial and full dentures
- Scaling and root planing
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

* Providers should consider sedation and general anesthesia when they determine and document a reason local anesthesia is not medically appropriate, and the dental treatment is pre-approved or does not need pre-approval (prior authorization).

These are some of the reasons local anesthesia cannot be used and sedation or general anesthesia might be used instead:

- Physical, behavioral, developmental, or emotional condition that blocks the patient from responding to the provider's attempts to perform treatment

- Major restorative or surgical procedures
- Uncooperative child
- Acute infection at an injection site
- Failure of a local anesthetic to control pain

If you have questions or want to learn more about dental services, call the Medi-Cal Dental Customer Service Line at **1-800-322-6384** (TTY **1-800-735-2922** or **711**), or go to https://smilecalifornia.org/.

Revised description under "State Hearings" in Chapter 6 (Reporting and solving problems)

State Hearings

A State Hearing is a meeting with us and a judge from the California Department of Social Services ("CDSS"). The judge will help to resolve your problem and decide whether we made the correct decision or not. You have the right to ask for a State Hearing if you already asked for an appeal with Kaiser Permanente and you are still not happy with our decision, or if you did not get a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 calendar days from the date on our Notice of Appeal Resolution ("NAR") letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 calendar days of our NAR letter or before the date we said your services will stop, whichever is later.

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact our Member Services at **1-855-839-7613** (TTY **711**) 24 hours a day, 7 days a week. Your authorized representative or provider can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process.

For example, you can request a State Hearing without having to complete our appeal process, if we did not notify you correctly or on time about your services. This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- We did not make a Notice of Action ("NOA") or NAR letter available to you in your preferred language
- We made a mistake that affects any of your rights
- We did not give you an NOA letter

- We did not give you an NAR letter
- We made a mistake in our NAR letter
- We did not decide your appeal within 30 days
- We decided your case was urgent but did not respond to your appeal within 72 hours

You can ask for a State Hearing in these ways:

- **By phone:** Call CDSS' State Hearings Division at **1-800-743-8525** (TTY **1-800-952-8349** or **711**)
- **By mail**: Fill out the form provided with your appeals resolution notice and mail it to:

  California Department of Social Services
  State Hearings Division
  744 P Street, MS 09-17-433
  Sacramento, CA 95814
- **Online:** Request a hearing online at **www.cdss.ca.gov**
- **By email:** Fill out the form that came with your appeals resolution notice and email it to **Scopeofbenefits@dss.ca.gov**
  - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.
- **By Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division at **916-309-3487** or toll free at **1-833-281-0903**

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call [our Member Services at **1-855-839-7613** (TTY **711**).

At the hearing, you will tell the judge why you disagree with our decision. We will tell the judge how we made our decision. It could take up to 90 days for the judge to decide your case. We must follow what the judge decides.

If you want CDSS to make a fast decision because the time it takes to have a State Hearing would put your life, health, or ability to function fully in danger, you, your authorized representative, or your provider can contact CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than three business days after it gets your complete case file from us.

Revised description under “Notice of Action” in Chapter 7(Rights and responsibilities)

As a member of Kaiser Permanente, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of Kaiser Permanente.

Notice of Action

Kaiser Permanente will send you a Notice of Action (“NOA”) letter any time Kaiser Permanente denies, delays, terminates, or modifies a request for health care services. If you disagree with our decision, you can always file an appeal with us. Go to the “Appeals” section in Chapter 6 of this Member handbook for important information on filing your appeal. When we send you an NOA it will tell you all the rights you have if you disagree with a decision we made. If you get this notice from anyone other than us , contact Kaiser Permanente right away.

Contents in notices

If we base denials, delays, modifications, terminations, suspensions, or reductions to your services in whole or in part on medical necessity, your NOA must contain the following:

- A statement of the action we intend to take
- A clear and concise explanation of the reasons for our decision
- How we decided, including the rules we used
- The medical reasons for the decision. We must clearly state how your condition does not meet the rules or guidelines.
- Information about your right to request free of charge copies of all documents and records relevant to the NOA.

Translations

We are required to fully translate and provide written member information in common preferred languages, including all grievance and appeals notices.

The fully translated notice must include the medical reason for our decision to deny, delay, modify, terminate, suspend, or reduce a request for health care services.

If translation in your preferred language is not available, we will provide verbal help in your preferred language so that you can understand the information you get.

Nondiscrimination Notice

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

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

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

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

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

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

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

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

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

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

English: Attention: If you need help in your language, call **1-855-839-7613** (TTY **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. You can also ask for materials translated into your language, or in alternative formats. Call **1-855-839-7613** (TTY **711**). These services are free.

Arabic: تنبيه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم **1-855-839-7613** (TTY **711**). كما وتتوفر مساعدات وخدمات للأشخاص الذين يعانون من إعاقات مثل وثائق بلغة برايل والطباعة بخط كبير. يمكنك أيضاً طلب وثائق مترجمة بلغتك أو بصيغ بديلة. اتصل على الرقم **1-855-839-7613** (TTY **711**). هذه الخدمات مجانية.

Armenian: Ուշադրություն. եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք **1-855-839-7613** (TTY **711**): Մատչելի են նաև աջակցություններ և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպես օրինակ՝ փաստաթղթեր բրեյլով կամ մեծ տառատեսակով: Կարող եք նաև հայցել ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափերով նյութեր: Զանգահարեք **1-855-839-7613** (TTY **711**): Այս ծառայություններն անվճար են:

Chinese：**请注意：**如果您需要语言协助，请致电 **1-800-757-7585** (TTY **711**)。我们也为残障人士提供援助和服务，例如盲文和大字版文件。您还可以索要翻译为您所用语言或其他格式的材料。请致电 **1-800-757-7585** (TTY **711**)。这些服务免费。

Farsi: توجه: اگر نیاز به کمک به زبان خودتان دارید با شماره **1-855-839-7613** (TTY **711**) تماس بگیرید. کمک‌ها و خدمات برای افراد دچار معلولیت، مانند اسناد با خط بریل و چاپ بزرگ نیز در دسترس است. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین درخواست کنید. با شماره **1-855-839-7613** (TTY **711**) تماس بگیرید. این خدمات رایگان است.

Hindi: ध्यान दें: अगर आपको अपनी भाषा में सहायता चाहिए, तो **1-855-839-7613** (TTY **711**) पर कॉल करें। विकलांग व्यक्तियों के लिए सहायताएँ और सेवाएँ, जैसे कि ब्रेल और बड़े प्रिंट में दस्तावेज़, उपलब्ध हैं। आप सामग्रियों को अपनी भाषा, या वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी कह सकते हैं। **1-855-839-7613** (TTY **711**) पर कॉल करें। ये सेवाएँ मुफ़्त होती हैं।

Hmong: Ceeb toom: Yog koj yuav tau muaj kev pab ua koj yam lus, hu rau **1-855-839-7613** (TTY **711**). Kuj muaj cov kev pab cuam rau cov neeg uas muaj qhov kev tsis ua taus, xws li cov ntaub ntawv ua pob su rau cov dig muag thiab cov tsiaj ntawv loj. Koj kuj thov kom tau ntaub ntawv txhais ua koj yam lus, lossis ua lwm yam los tau. Hu **1-855-839-7613** (TTY **711**). Cov kev pab no muab pub dawb.

Japanese: 注意：言語でサポートが必要な場合は、 **1-855-839-7613** (TTY **711**) までお電話ください。点字や大きな活字で書かれたなど、障害者のための補助やサービスも用意されている。また、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることもできます。 **1-855-839-7613** (TTY **711**) までお電話ください。これらのサービスは無料です。

Khmer: **យកចិត្តទុកដាក់៖**
ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរស័ព្ទទៅ **1-855-839-7613** (TTY **711**)។ ជំនួយ
និងសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារជាអក្សរស្ទាប និងអក្សរធំៗក៏មានផងដែរ។
អ្នកក៏អាចស្នើសុំឯកសារដែលបានបកប្រែជាភាសារបស់
អ្នក ឬក្នុងទម្រង់ផ្សេង។ សូមទូរស័ព្ទទៅ **1-855-839-7613**
(TTY **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ។

Korean: 주의: 귀하의 언어로 도움이 필요하시면
1-855-839-7613 (TTY **711**)번으로 전화하십시오.
점자 및 큰 활자로 된 문서 등 장애인을 위한 지원 및
서비스도 제공됩니다. 또한 귀하의 언어로 번역된
자료 또는 대체 형식의 자료를 요청할 수
있습니다. **1-855-839-7613** (TTY **711**)번으로
전화하십시오. 이러한 서비스는 무료입니다.

Laotian: ຊຶ່ນຊາບ:
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໂທຫາເບີ **1-855-839-7613** (TTY **711**). ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການແມ່ນມີໃຫ້ຊຶ່ນ: ເອກະສານເປັນຕົວໜັງສືນູນ ແລະ ສື່ສິ່ງພິມໃຫຍ່. ທ່ານຍັງສາມາດຂໍເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໆໄດ້. ໂທຫາເບີ **1-855-839-7613** (TTY **711**). ການບໍລິການນີ້ແມ່ນບໍ່ເສຍຄ່າ.

Mien: Cau fim jangx longx oc: Beiv hnangv meih qiemx zuqc longc mienh tengx faan benx meih nyei waac bun muangx nor, douc waac lorx **1-855-839-7613** (TTY **711**). Maaih jaa-sic tengx aengx caux tengx nzie weih bun wuaaic fangx mienh, liepc duqv maaih nzangc-pokc bun hluo aengx caux aamx cuotv domh zeiv daan bun longc. Meih corc haih tov heuc dorh naaiv deix jaa-sic mingh zoux benx meih nyei waac, a'fai zoux benx da'nyeic nyungc guv bun. Douc waac lorx **1-855-839-7613** (TTY **711**). Naaiv deix gong-bou jauv-louc se wangv henh tengx hnangv oc.

Navajo: Ńt'éé': Hadiilnéhgo shizaad k'ehjí shíká ahił halne'go, bił hane' **1-855-839-7613** (TTY **711**) Ałch'į' ádaats'íísígíí dóó ał'ąą ał'ąą ak'e'edzáhígíí baa hane'go, naaltsoos Braille dóó ch'įįh naaltsoos, éí kódahat'e'. Níigo éí yiká azhígíí shí bizaad bee yit'éého éí díí bidáhálne'go, doodago léechąąí bíla'ashdla'ii bíká'go éí dabikáá'go, yeidooleeł. Bił hane' **1-855-839-7613** (TTY **711**). Éí ał'ąą ał'ąą ak'éadzáhígíí díí bílaashdladi bee hahoodzo da.

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ **1-855-839-7613** (TTY **711**) 'ਤੇ ਕਾੱਲ ਕਰੋ। ਵਿਕਲਾਂਗ ਵਿਅਕਤੀਆਂ ਲਈ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਵੀ ਉਪਲਬਧ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। **1-855-839-7613** (TTY **711**) 'ਤੇ ਕਾੱਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Russian: Внимание: Если вам нужна помощь на вашем языке, позвоните **1-855-839-7613** (kbybz TTY **711**). Также доступны вспомогательные средства и услуги для людей с инвалидностью, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах. Звоните **1-855-839-7613** (линия TTY **711**). Эти услуги бесплатны.

Spanish: Atención: Si necesita ayuda en su idioma, llame al **1-800-788-0616** (TTY **711**). Se encuentran disponibles ayudas y servicios para personas con discapacidad, como documentos en braille y letra grande. También puede solicitar materiales traducidos a su idioma o en formatos alternativos. Llame al **1-800-788-0616** (TTY **711**). Estos servicios no tienen costo.

Tagalog: Paunawa: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-855-839-7613** (TTY **711**). Available din ang mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumento sa braille at malaking letra. Maaari ka ring humiling ng mga babasahin na isinalin sa iyong wika, o sa mga alternatibong format. Tumawag sa **1-855-839-7613** (TTY **711**). Libre ang mga serbisyong ito.

Thai: ข้อควรพิจารณา:
หากคุณต้องการความช่วยเหลือในด้านภาษา กรุณาโทร **1-855-839-7613** (TTY **711**) นอกจากนี้ ยังมีการให้ความช่วยเหลือและบริการแก่คนพิการ เช่น เอกสารอักษรเบรลล์และตัวพิมพ์ขนาดใหญ่อีกด้วย คุณยังสามารถขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นได้ โทร **1-855-839-7613** (TTY **711**) บริการเหล่านี้ไม่มีค่าใช้จ่าย

Ukrainian: Увага! Якщо вам потрібна допомога вашою мовою, телефонуйте за номером **1-855-839-7613** (телетайп **711**). Також доступні допоміжні засоби й послуги для людей з інвалідністю, наприклад документи, надруковані шрифтом Брайля чи великим шрифтом.
Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах. Телефонуйте за номером **1-855-839-7613** (телетайп **711**).
Ці послуги безплатні.

Vietnamese: Chú ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số **1-855-839-7613** (TTY **711**). Cũng có hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn. Quý vị cũng có thể yêu cầu các tài liệu được dịch sang ngôn ngữ của quý vị hoặc ở các định dạng khác. Hãy gọi **1-855-839-7613** (TTY **711**). Các dịch vụ này miễn phí.