

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hmsa.com.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary/> or call 1-800-776-4672 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>network providers</u> \$0 For <u>out-of-network providers</u> \$100 individual / \$300 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. All services received from a participating or in-network <u>provider</u> will be covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$2,500 individual / \$7,500 family (applies to medical <u>plan</u> coverage). \$3,600 individual / \$4,200 family (applies to <u>prescription drug</u> coverage).	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed charges</u> , payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your <u>copayment</u> for covered services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$12 <u>copay</u> /visit	30% <u>coinsurance</u>	---none---
	Specialist visit	\$12 <u>copay</u> /visit	30% <u>coinsurance</u>	---none---
	Other practitioner office visit:			
	Physical and Occupational Therapist	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Psychologist	\$12 <u>copay</u> /visit	30% <u>coinsurance</u>	---none---
	Nurse Practitioner	\$12 <u>copay</u> /visit	30% <u>coinsurance</u>	---none---
	<u>Preventive care</u> (Well Child Physician Visit)	No charge	30% <u>coinsurance</u> ; <u>deductible</u> does not apply	Age and frequency limitations may apply. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Screening</u>	No charge	30% <u>coinsurance</u>	
	Immunization (Standard and Travel)	No charge	30% <u>coinsurance</u>	
If you have a test	Diagnostic test			
	Inpatient	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Outpatient	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	X-ray			
	Inpatient	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Outpatient	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Blood Work			
	Inpatient	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Outpatient	20% <u>coinsurance</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Imaging (CT/PET scans, MRIs)			
	Inpatient	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Outpatient	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hmsa.com .	Tier 1 – mostly Generic drugs (retail)	\$7 <u>copay</u> /prescription	\$7 <u>copay</u> and 20% <u>coinsurance</u> /prescription; <u>deductible</u> does not apply	One retail <u>copay</u> for 1-30 day supply, two retail <u>copays</u> for 31-60 day supply, and three retail <u>copays</u> for 61-90 day supply.
	Tier 1 – mostly Generic drugs (mail order)	\$11 <u>copay</u> /prescription	Not covered	One mail order <u>copay</u> for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 2 – mostly Preferred Formulary Drugs (retail)	\$30 <u>copay</u> /prescription	\$30 <u>copay</u> and 20% <u>coinsurance</u> /prescription; <u>deductible</u> does not apply	One retail <u>copay</u> for 1-30 day supply, two retail <u>copays</u> for 31-60 day supply, and three retail <u>copays</u> for 61-90 day supply.
	Tier 2 – mostly Preferred Formulary Drugs (mail order)	\$65 <u>copay</u> /prescription	Not covered	One mail order <u>copay</u> for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 3 – mostly Non-preferred Formulary Drugs (retail)	\$30 <u>copay</u> /prescription	\$30 <u>copay</u> and 20% <u>coinsurance</u> /prescription; <u>deductible</u> does not apply	In addition to your <u>copay</u> and/or <u>coinsurance</u> , you will be responsible for a \$45 Tier 3 Cost Share per retail copay . Cost to you for retail Tier 3 drugs: One <u>copay</u> plus one Tier 3 Cost Share for 1-30 day supply, two <u>copays</u> plus two Tier 3 Cost Shares for 31-60 day supply, and three <u>copays</u> plus three Tier 3 Cost Shares for 61-90 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmsa.com .	Tier 3 – mostly Non-preferred Formulary Drugs (mail order)	\$65 <u>copay</u> /prescription	Not covered	In addition to your <u>copay</u> and/or <u>coinsurance</u> , you will be responsible for a \$135 Tier 3 Cost Share per mail order copay . Cost to you for mail order Tier 3 drugs: One mail order <u>copay</u> plus one mail order Tier 3 Cost Share for an 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 4 – mostly Preferred Formulary <u>Specialty drugs</u> (retail)	\$100 <u>copay</u> /prescription	Not covered	Retail benefits for Tier 4 and Tier 5 drugs are limited to a 30-day supply. Available in participating Specialty Pharmacies only.
	Tier 5 – mostly Non-preferred Formulary <u>Specialty drugs</u> (retail)	\$200 <u>copay</u> /prescription	Not covered	
	Tier 4 & 5 (mail order)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	Physician Visits	\$12 <u>copay</u> /visit	30% <u>coinsurance</u>	---none---
	Surgeon fees	10% <u>coinsurance</u> (cutting)	30% <u>coinsurance</u> (cutting)	---none---
		20% <u>coinsurance</u> (non-cutting)	30% <u>coinsurance</u> (non-cutting)	---none---
If you need immediate medical attention	<u>Emergency room care</u>			
	Physician Visit	\$12 <u>copay</u> /visit	\$12 <u>copay</u> /visit; <u>deductible</u> does not apply	---none---
	<u>Emergency room</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	---none---
	<u>Emergency medical transportation</u> (air)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to air transport to the nearest adequate hospital within the State of Hawaii, except in certain situations when transportation to the continental US is necessary for critical care in accord with HMSA's medical policy. Certain exclusions apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency medical transportation (ground)</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	<u>Urgent care</u>	\$12 <u>copay/visit</u>	30% <u>coinsurance</u>	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	Physician Visits	\$12 <u>copay/visit</u>	30% <u>coinsurance</u>	---none---
	Surgeon fee	10% <u>coinsurance</u> (cutting)	30% <u>coinsurance</u> (cutting)	---none---
		20% <u>coinsurance</u> (non-cutting)	30% <u>coinsurance</u> (non-cutting)	---none---
If you have mental health, behavioral health, or substance abuse needs	Outpatient services			
	Physician services	\$12 <u>copay/visit</u>	30% <u>coinsurance</u>	---none---
	Hospital and facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	Inpatient services			
	Physician services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	Hospital and facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
If you are pregnant	Office visit (Prenatal and postnatal care)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> or <u>copay</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	150 Visits per Calendar Year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained. Excludes cardiac rehabilitation.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Excluded service</u>
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	120 Days per Calendar Year. Includes extended care facilities (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) to the extent care is for <u>Skilled nursing care</u> , sub-acute care, or long-term acute care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Durable medical equipment	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services may require <u>preauthorization</u> . Benefits may be denied if <u>preauthorization</u> is not obtained.
	Hospice services	No charge	Not covered	---none---
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	<u>Excluded service</u>
	Children's glasses (single vision lenses and frames selected within designated group)	Not covered	Not covered	<u>Excluded service</u>
	Children's dental check-up	Not covered	Not covered	<u>Excluded service</u>

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture	• Dental care (Child)	• Routine eye care (Adult)
• Cardiac rehabilitation	• Habilitation services	• Routine eye care (Child)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Bariatric surgery	• Infertility Treatment (Artificial Insemination and In Vitro Fertilization. Please refer to your plan document for limitations and additional details)	
• Chiropractic care (e.g., office visits, x-ray films – limited to services covered by this medical plan and within the scope of a chiropractor's license)	• Non-emergency care when traveling outside the U.S. For more information, see www.hmsa.com	
• Hearing aids (limited to one hearing aid per ear every 60 months)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1) 1-800-776-4672 for HMSA; 2) (808) 586-2790 for the State of Hawaii, Dept. of Commerce and Consumer Affairs – Insurance Division; 3) 1-866-444-3272 or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act> for the U.S. Department of Labor, Employee Benefits Security Administration; or 4) 1-877-267-2323 x61565 or <http://www.cciio.cms.gov> for the U.S. Department of Health and Human Services. Church plans are not covered by the Federal COBRA continuation coverage rules. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act>. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.
- For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

Does this Coverage Provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-776-4672.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$12
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,380

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$12
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$12
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$470

The plan would be responsible for the other costs of these EXAMPLE covered services.

Federal law requires HMSA to provide you with this notice.

HMSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HMSA does not exclude people or treat them differently because of things like race, color, national origin, age, disability, or sex.

Services that HMSA provides

Provides aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages
- If you need these services, please call 1 (800) 776-4672 toll-free; TTY 711

How to file a discrimination-related grievance or complaint

If you believe that we've failed to provide these services or discriminated against you in some way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free

- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

Hawaiian: E NĀNĀ MAI: Inā ho'opuka 'oe i ka 'Ōlelo Hawai'i, loa'a ke kōkua manuahi iā 'oe. E kelepona iā 1 (800) 776-4672. TTY 711.

Bisaya: ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 776-4672。TTY 711.

Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 776-4672 をご利用ください。TTY 711. まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 776-4672번으로 연락해 주시기 바랍니다. TTY 711 번으로 전화해 주십시오.

Laotian: ກະລຸນາສັງເກດ: ຖ້າທ່ານວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ແມ່ນມີໃຫ້ທ່ານ. ໂທ 1 (800) 776-4672 ພຣີ. TTY 711.

Marshallese: LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelōk

wōñān. Kaalōk 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Pohnpeian: Ma ke kin lokaian Pohnpei, ke kak ale sawas in sohte pweine. Kahlda nempe wet 1 (800) 776-4672. Me sohte kak rong call TTY 711.

Samoan: MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totogi o lenei 'au'aunaga. TTY 711.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 776-4672. TTY 711.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1 (800) 776-4672. TTY 711.

Trukese: MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1 (800) 776-4672, ese kamo. TTY 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 776-4672. TTY 711.



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