MFOW WELFARE FUND
240 2ND STREET
SAN FRANCISCO CA 94105

August 15, 2023

TO: ALL PLAN PARTICIPANTS COVERED UNDER THE PHS REPLACEMENT PROGRAM HMO AND PPO MEDICAL AND PRESCRIPTION DRUG PLANS

RE: IMPORTANT NOTICE REGARDING YOUR HEALTH CARE COVERAGE ANNUAL SUMMARY OF BENEFITS COVERAGE FORM

Attached is a copy of the most recent Summary of Benefits Coverage Form outlining the Medical and Prescription Drug Plan benefits in which you are currently enrolled through the MFOW Welfare Benefit Plan and notices prepared by various providers highlighting some of the benefit changes for the year.

The summary of changes outlined below, together with the enclosed Summary of Benefits Coverage Forms, constitute the "summary of material modifications" of the benefits provided under the medical plan options described in the Forms. Please keep this summary with your copy of the Summary Plan Description and your Evidence of Coverage.

If you wish to review the Summary of Benefits Coverage Forms for any of the other HMO/PPO plans and/or wish to make a change to one of the other HMO plans available to you, please contact the Welfare Fund Office (415) 986-1028 (240 Second Street, San Francisco, CA 94105). You have through September 30, 2023 to make any changes to your plan selection for an October 1, 2023 effective date.

If you wish to receive a hard copy of this notice, please contact the Welfare Fund Office. Summary of Benefits Coverage Forms for all HMO and PPO plans can be found at www.mfoww.org under the "Downloads" tab.

The following is a summary of the major Plan clarifications or changes (note that all benefits are subject to the terms of the plan document and applicable group insurance policy and Evidence of Coverage):

Kaiser Northern and Southern California Plans: Effective October 1, 2023, there are no substantial benefit changes, except, the following two copayment changes will apply:

1. *Mental Health Services.* The copayment for Mental Health Outpatient Intensive ABA Program for Autism will change from $20 per day to $0 per day.

2. *Chemical Dependency Services.* The copayment for Chemical Dependency Outpatient Intensive Outpatient Program will change from $5 per day to $0 per day.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Kaiser Hawaii Plan: Effective October 1, 2023, there are no contract changes however the following

two clarifications apply:

1. *Home Phototherapy Equipment*. Clarify language that the home phototherapy equipment benefit applies to all members.

2. *Specialty Drugs*. Clarify language that specialty drugs available through mail order are covered at the usual Drug Rider copay for a 30-day supply.

For details on your coverage, please refer to your Kaiser Permanente Hawaii's Guide to Your Health Plan that can be obtained from the Fund Office or Kaiser.

Kaiser Washington Plan: Effective October 1, 2023, the following changes and/or clarifications apply. This list is not all-inclusive and you should refer to your 2023 Benefit Booklet for a complete list.

1. *Emergency Services* – If you need emergency services while traveling and are admitted to a non-network hospital, You or a family member must notify Kaiser with 24 hours (formerly 48 hours) or as soon as reasonably possible.

2. *Emergency ambulance* service is covered only when:
   - Transport is to the nearest facility that can treat your condition
   - Any other type of transport would put your health or safety at risk
   - The service is from a licensed ambulance.
   - The ambulance transports you to a location where you receive covered services.

3. *Ambulance Coverage Clarification*: Non-Emergency ground or air interfacility transfer to or from a Network Facility where you receive covered services when preauthorized by Kaiser Foundation Health Plan of Washington (KFHPWA) is covered. Contact Member Services for Preauthorization.

4. *New Benefit Advanced Care at Home* - is a patient centered program designed to provide hospital-level acute care and clinical services to Members with certain diagnoses at home under the direction of KFHPWA physicians. If a Member is admitted as an inpatient or to Advanced Care at Home directly from an emergency department, any emergency services copayment is waived. Coverage is subject to the hospital services Cost Share.

5. *Out-patient Prescription Drugs* - For outpatient prescription drugs and/or items that are covered under the Drugs –Outpatient Prescription section and obtained at a pharmacy owned and operated by KFHPWA, a Member may be able to use approved manufacturer coupons as payment for the Cost Sharing that a Member owes, as allowed under KFHPWA's coupon program. A Member will owe any additional amount if the coupon does not cover the entire amount of the Cost Sharing for the Member's prescription. When a Member uses an approved coupon for payment of their Cost Sharing, the coupon amount and any additional payment that they make will accumulate to their Out-of-Pocket Limit. More information is available regarding the Kaiser Permanente coupon program rules and limitations at www.kp.org/rxcoupons.

6. Eligibility, Enrollment and *Termination – Continuation of Inpatient Services – Benefit Change* – Continuation of Inpatient services for a Member who is in the hospital on the date of termination of eligibility will no longer be covered under the contract. Therefore, you will be responsible for paying for any services provided on or after your termination date.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage

provisions.

Kaiser Oregon Plan: Effective October 1, 2023, there are no plan changes.

You should refer to your 2023 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Health Net HMO and PPO Plans: The PPO Plans include some administrative and regulatory changes that Health Net is implementing effective October 1, 2023. There are no changes to the HMO Plan provisions effective October 1, 2023.

(refer to attached Health Net notices for a list of all other changes and clarifications effective at renewal)

You should refer to your 2023 Health Net Benefit Booklet for a complete list of your plan benefits and coverage provisions.

Grandfathered Group Health Plans

The Welfare Fund's Board of Trustees has concluded that the HMO and PPO Plans are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of certain lifetime limits on benefits.

Although it is a "grandfathered health plan", you should know that the Plan provides health coverage \benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on required work hours. Nor does the Plan discriminate in favor of certain members based on compensation, age, gender, or health status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (415) 986-1028. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

KAISER PERMANENTE®: HMO Group Plan

Coverage for: Individual / Family | Plan Type: HMO

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 see https://kp.org/plandocuments or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands . 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 www.healthcare.gov/sbc-glossary/ or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual/ $4,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$14/visit	Not Covered	None
	Specialist visit	$14/visit	Not Covered	None
	Preventive care/ screening/ immunization	No charge for immunizations; No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	Inpatient fee included in hospital stay
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	$10 retail; No Charge mail order/ prescription	Not Covered	Up to 30-day retail or 90-day mail order. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Specialty drugs	$10 retail prescription	Not Covered	Up to 30-day retail. No charge contraceptives in accordance with formulary guidelines. Certain drugs may be covered at a different cost share.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$14/visit	Not Covered	None
	Physician/surgeon fees	No charge	Not Covered	Physican/surgeon fees are included in the facility fee.
If you need immediate medical attention	Emergency room care	$25/visit in-area; 20% coinsurance out-of-area	$25/visit in-area; 20% coinsurance out-of-area	Must notify KP within 48 hours if admitted to a non plan provider; Limited to initial emergency only
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$14/visit, 20% coinsurance (out of area)	$14/visit, 20% coinsurance (out of area)	Non-plan providers are not covered inside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$14/visit	Not Covered	None
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No charge	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	Delivery: No charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	Physician visit covered at primary care visit copay
	Rehabilitation services	$14/visit (outpatient); No Charge (inpatient).	Not Covered	None
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services
	Skilled nursing care	No Charge	Not Covered	Limited to 120 days/benefit period
	Durable medical equipment	20% coinsurance	Not Covered	Diabetic supplies: 50% coinsurance. Subject to formulary guidelines.
	Hospice service	No Charge	Not Covered	Includes two 90-day periods, followed by unlimited number of 60-day periods
If your child needs dental or eye care	Children's eye exam	$14 / visit for refractive exam	Not Covered	Limited to 1 exam / year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	Limited to 1 diagnostic exam and 2 preventive cleanings /calendar year from Hawaii Dental Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Habilitation services
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Travelling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Dental care (Adult, $1,200 limit / person / year)
- Hearing Aids (Every 3 years)
- Infertility Treatment
- Routine eye care (Adult)

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 shown in the chart below. 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 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Hawaii Department of Insurance	1-808-586-2790 or http://cca.hawaii.gov/ins/

Does this plan 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 plan meet the Minimum Value Standards? **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 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-808-432-5955 (TTY: 711) in Oahu or 1-800-966-5955 (TTY: 711) in Neighbor Islands

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

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** **$14**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$10**

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** **$14**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$14**
- **Hospital (facility) copayment** **$0**
- **Other (x-ray) copayment** **$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

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

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (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 **1-800-966-5955** （TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-966-5955** (TTY: **711**).

‘Ōlelo Hawai‘i (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ‘oe i ka ‘ōlelo Hawai‘i, hiki iā ‘oe ke loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka. Awagan ti **1-800-966-5955** (TTY: **711**).

日本語（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。**1-800-966-5955**（TTY:**711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: **711**)번으로 전화해 주십시오.

ลาว (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais. Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA'I: Kapau 'oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-966-5955** (TTY: **711**).