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.

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, www.kp.org/plandocuments or call 1-888-901-4636 (TTY: 711). 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 1-888-901-4636 (TTY: 711) 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.
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?	Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Not Applicable.	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 1-888-901-4636 (TTY: 711) 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	No charge	Not covered	None
	Specialist visit	No charge	Not covered	None
	Preventive care/screening/ immunization	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, MRIs)	No charge	Not covered	Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Preferred generic drugs	No charge (retail / mail)	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines.
	Preferred brand drugs	No charge (retail / mail)	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines.
	Non-preferred drugs	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply.	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines . when approved through the exception process.
	Specialty drugs	Applicable Preferred generic, Preferred brand or Non-Preferred cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	No charge	$50 / visit, then No charge	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	No charge	$50 / visit, then No charge	Non-network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	No charge	Not covered	Professional services are included in the Facility services. Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	Preauthorization required or will not be covered.
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	Professional services are included in the Facility services. You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
	Childbirth/delivery facility services	No charge	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: No charge Inpatient: No charge	Not covered	Combined with Habilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Habilitation services	Outpatient: No charge Inpatient: No charge	Not covered	Combined with Rehabilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered.
	Skilled nursing care	No charge	Not covered	60 -day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam	Not covered	Limited to 1 exam / 12 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling 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.)

- Acupuncture (8 visit limit / year)
- Chiropractic care (10 visit limit / year)
- 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	1-888-901-4636 (TTY: 711) or www.kp.org
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.
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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 1-888-901-4636 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636 (TTY: 711).

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	$0
■ 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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$20**

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	$0
■ 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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

■ The plan's overall deductible	$0
■ Specialist copayment	$0
■ Hospital (facility) copayment	$0
■ Other (blood work) 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	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is *	**$0**

* Note: The Patient Pays amount is capped at the plan's out-of-pocket limit. Total amounts may not add up due to rounding.

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

Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal and Washington state civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. 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 (large print, audio, accessible electronic formats, and other formats)
  - Assistive devices (magnifiers, Pocket Talkers, and other aids)
- 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, contact Member Services at **1-888-901-4636** (TTY **711**).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at **kp.org/wa/feedback**. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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, 800-537-7697** (TDD) Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

Español (Spanish): ATENCIÓN: Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636** (TTY **711**).

中文 (Chinese)：注意：如果您說中文，您可以免費獲得語言援助服務。請致電 **1-888-901-4636** (TTY **711**)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636** (TTY **711**).

한국어 (Korean): 참고: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636**(TTY **711**)번으로 문의하십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636** (TTY **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636** (TTY **711**).

ភាសាខ្មែរ (Khmer)៖ **សូមយកចិត្តទុកដាក់៖** ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺ មានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **1-888-901-4636** (TTY **711**)។

日本語 (Japanese): 注意事項：無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636** (TTY **711**) まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማሳሰቢያ፥ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እገዛ አገልግሎቶች፣ በነጻ ለእርስዎ ይቀርባሉ፡ ወደ **1-888-901-4636** (TTY **711**) ይደውሉ።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa yoo ta’e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636** (TTY **711**) irraatti bilbilaa.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। **1-888-901-4636** (TTY **711**) ‘ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): انتباه إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل بالرقم **1-888-901-4636** (TTY **711**)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY **711**).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທ **1-888-901-4636** (TTY **711**).