

 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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$300 individual / \$900 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Certain <a href="#">preventive care</a> and well-child care services will be covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific service?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$5,000 individual / \$10,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed charges</a> , payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your <a href="#">copayment</a> for covered services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.hmsa.com/search/providers">http://www.hmsa.com/search/providers</a> or call 1-800-776-4672 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	<a href="#">Specialist</a> visit	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	<b>Other practitioner office visit:</b>			
	Physical and Occupational Therapist	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	Psychologist	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	Nurse Practitioner	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	<a href="#">Preventive care</a> (Well Child Physician Visit)	No charge; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Age and frequency limitations may apply. You may have to pay for
	<a href="#">Screening</a>	No charge; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed
	Contraceptive Implants, Injectables, & IUDs	No charge; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	Immunization (Standard and Travel)	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	
If you have a test	<a href="#">Diagnostic test</a>			
	Inpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	Outpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<b>X-ray</b>			
	Inpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if
Outpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">preauthorization</a> is not obtained.	

	<b>Blood Work</b>			
	Inpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	Outpatient	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	
	<b>Imaging (CT/PET scans, MRIs)</b>			
	Inpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
Outpatient	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>		
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hmsa.com">www.hmsa.com</a>.</p>	<b>Generic drugs (retail)</b>			
	Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
	Contraceptives – Diaphragms/ Cervical Caps	Not covered	Not covered	
	Diabetic Drugs	Not covered	Not covered	
	Insulin	Not covered	Not covered	
	Oral Chemotherapy	Not covered	Not covered	
	Over the Counter Contraceptives	Not covered	Not covered	
	USPSTF Recommended Drugs	Not covered	Not covered	
	<b>Generic drugs (mail order)</b>			
	Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
	Contraceptives – Diaphragms/ Cervical Caps	Not covered	Not covered	
	Diabetic Drugs	Not covered	Not covered	
	Insulin	Not covered	Not covered	
	Oral Chemotherapy	Not covered	Not covered	
	Over the Counter Contraceptives	Not covered	Not covered	
	USPSTF Recommended Drugs	Not covered	Not covered	
	<b>Preferred Formulary Drugs (retail)</b>			
	Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
	Contraceptives – Diaphragms/	Not covered	Not covered	

Cervical Caps			
Diabetic Drugs	Not covered	Not covered	
Diabetic Supplies	Not covered	Not covered	
Insulin	Not covered	Not covered	
Oral Chemotherapy	Not covered	Not covered	
Over the Counter Contraceptives	Not covered	Not covered	
USPSTF Recommended Drugs	Not covered	Not covered	
<b>Preferred Formulary Drugs (mail order)</b>			
Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
Contraceptives – Diaphragms/ Cervical Caps	Not covered	Not covered	
Diabetic Drugs	Not covered	Not covered	
Diabetic Supplies	Not covered	Not covered	
Insulin	Not covered	Not covered	
Oral Chemotherapy	Not covered	Not covered	
Over the Counter Contraceptives	Not covered	Not covered	
USPSTF Recommended Drugs	Not covered	Not covered	
<b>Non-preferred Formulary Drugs (retail)</b>			
Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
Contraceptives – Diaphragms/ Cervical Caps	Not covered	Not covered	
Diabetic Drugs	Not covered	Not covered	
Diabetic Supplies	Not covered	Not covered	
Insulin	Not covered	Not covered	
Oral Chemotherapy	Not covered	Not covered	
Over the Counter Contraceptives	Not covered	Not covered	
USPSTF Recommended Drugs	Not covered	Not covered	

	<b>Non-preferred Formulary Drugs (mail order)</b>			
	Contraceptives – Oral & Other Methods	Not covered	Not covered	---none---
	Contraceptives – Diaphragms/ Cervical Caps	Not covered	Not covered	
	Diabetic Drugs	Not covered	Not covered	
	Diabetic Supplies	Not covered	Not covered	
	Insulin	Not covered	Not covered	
	Oral Chemotherapy	Not covered	Not covered	
	Over the Counter Contraceptives	Not covered	Not covered	
	USPSTF Recommended Drugs	Not covered	Not covered	
	<u>Specialty drugs</u>	Not covered	Not covered	---none---
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Physician Visits	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	---none---
	Surgeon fees	25% <u>coinsurance</u> (cutting)	40% <u>coinsurance</u> (cutting)	---none---
		25% <u>coinsurance</u> (non-cutting)	40% <u>coinsurance</u> (non-cutting)	---none---
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>			
	Physician Visit	25% <u>coinsurance</u>	25% <u>coinsurance</u>	---none---
	<u>Emergency room</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	---none---
	<u>Emergency medical transportation (air)</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	<u>Emergency medical transportation (ground)</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	<u>Urgent care</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Physician Visits	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	---none---

	Surgeon fee	25% <a href="#">coinsurance</a> (cutting)	40% <a href="#">coinsurance</a> (cutting)	---none---
		25% <a href="#">coinsurance</a> (non-cutting)	40% <a href="#">coinsurance</a> (non-cutting)	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	<b>Outpatient services</b>			
	Physician services	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	Hospital and facility services	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	---none---
	<b>Inpatient services</b>			
	Physician services	25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	---none---
	Hospital and facility services	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	---none---
<b>If you are pregnant</b>	Office visit (Prenatal and postnatal care)	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">copay</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	150 Visits per Calendar Year
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained. Excludes cardiac rehabilitation.
	<a href="#">Habilitation services</a>	Not covered	Not covered	<a href="#">Excluded service</a>
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	120 Days per Calendar Year.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services may require <a href="#">preauthorization</a> . Benefits may be denied if <a href="#">preauthorization</a> is not obtained.
	<a href="#">Hospice services</a>	No charge	Not covered	---none---
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	<a href="#">Excluded service</a>
	Children's glasses (single vision lenses and frames selected within designated group)	Not covered	Not covered	<a href="#">Excluded service</a>
	Children's dental check-up	Not covered	Not covered	<a href="#">Excluded service</a>

## 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            | • 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 [plan](#) document.)

- |   |  |
|---|--|
| • Bariatric surgery (requires precertification)                     | • Infertility treatment (requires precertification and limited to a one time only benefit for one outpatient procedure while you are an HMSA member) |
| • Chiropractic care (through American Specialty Health)             | • Non-emergency care when traveling outside the U.S. For more information, see <a href="http://www.hmsa.com">www.hmsa.com</a>                        |
| • 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/ebsa/healthreform> 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 [www.HealthCare.gov](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/ebsa/healthreform>. 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**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### **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](#) **\$300**
- [Specialist coinsurance](#) **25%**
- [Hospital \(facility\) coinsurance](#) **25%**
- [Other coinsurance](#) **25%**

**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** **\$12,800**

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$50
Coinsurance	\$3,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,510</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$300**
- [Specialist coinsurance](#) **25%**
- [Hospital \(facility\) coinsurance](#) **25%**
- [Other coinsurance](#) **25%**

**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** **\$7,400**

**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$500
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,560</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) **\$300**
- [Specialist coinsurance](#) **25%**
- [Hospital \(facility\) coinsurance](#) **25%**
- [Other coinsurance](#) **25%**

**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** **\$1,900**

**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

**Note:** These coverage examples address medical [plan](#) costs as administered by HMSA; for more information on outpatient [prescription drug](#) coverage costs as administered by Caremark, please visit [www.caremark.com](http://www.caremark.com) or call 1-855-801-8263.

**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](http://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](http://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。TTT 711。また、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: ຖ້າທ່ານວິໄນພາສາລາວ, ການຊ່ວຍເຫຼືອອດ້ານພາສາ, 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 ejjeļok

wōñān. Kaalok 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 auunaga fesoasoan, e fai fua e leai se totoi, mo oe, Telefoni mai: 1 (800) 776-4672 e leai se totoi o lenei 'au'unaga. 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': Kapau 'oku ke LeaFakatonga, 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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