DELTA DENTAL®

HDS
Hawaii Dental Service

HawaiiDentalService.com

Aloha!

Thank you for contacting **Hawaii Dental Service (HDS),** Hawaii's first and leading dental benefits provider, and for expressing interest in our individual dental plans.

HDS's Individual Dental Plans are perfect for: children who need a dental plan, students who are no longer covered on a parent's plan, the self-employed, those working full- or part-time without dental benefits, those between jobs and no longer on COBRA, and retirees.

All of our dental plans that include pediatric dental coverage are compliant with the Affordable Care Act. Enroll in an HDS Individual Dental Plan to ensure a lifetime of healthy smiles for you and your family.

HDS Individual Dental Plans include:

- 100% coverage for two exams and cleanings per year for adults and children
- 100% coverage for fluoride and sealants for children
- Enhanced benefits for members with a documented history of medical conditions such as cancer, diabetes, Sjogren's syndrome, stroke, heart attack, heart failure, kidney failure, and organ transplants.
- Freedom to choose from the largest network of dentists and specialists in Hawaii
- Coverage for visits to Delta Dental Premier participating dentists on the Mainland
- Local customer service and claims processing

The enclosed packet includes HDS's Individual Dental Plan Terms & Conditions, a comparison chart to help you compare benefits across our various plans, and a rate chart based on age to help you calculate what your monthly premium would be.

If you have any questions about our dental plans or need assistance in completing the application form, please contact our Customer Service department at 529-9248 from Oahu, toll-free at 1-844-379-4325, or via email at CS@HawaiiDentalService.com. You may also enroll and pay directly online at HawaiiDentalService.com.

Mahalo,

Hawaii Dental Service

2019 IDP PL-06.20.2018-MO

Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

Telephone: 808-521-1431
Toll Free: 800-232-2533
Fax: 808-529-9368

DELTA DENTAL

HDS
Hawaii Dental Service

Application Form for Individual Dental Plans

PLEASE TYPE OR PRINT IN BLACK INK
COMPLETE SECTIONS 1-4

Customer Service: (808) 529-9248 or
Toll-Free: 1-844-379-4325
HawaiiDentalService.com

The Application Form must be received by the 25th of the month to take effect the first of the following month

Please send completed application to:
Hawaii Dental Service
Attn: IDP Department
700 Bishop Street, Suite 700
Honolulu, HI 96813

Section 1 | RESPONSIBLE PARTY INFORMATION

Desired Effective Date: __ __/ 01 /20__ __ (M M / Y Y)

Last Name	First Name	Middle Initial	☐ Male ☐ Female

Home Address (Mailing)	City	State	Zip	Phone No. (with area code)
				(__ __ __) __ __ __ - __ __ __ __

Email Address*	Date of Birth (MM/DD/YYYY)	Age
	__ __ /__ __ /__ __ __ __	

**By providing my email address, I agree to receive communications regarding my policy and benefits electronically.*

I AM ELECTING COVERAGE FOR MYSELF ☐ YES ☐ NO;
If "NO," I acknowledge that I am the responsible party for the members listed in Section 2.

PLAN SELECTION:

☐ **HDS Classic** Dental Plan #2525
☐ **HDS Preferred** Dental Plan #2851
☐ **HDS Deluxe** Dental Plan #1061
☐ HDS Individual Dental Plan for **Children** #2999 *(Children only, through age 25)*
☐ **HDS Basic** Dental Plan #1059 *(Adults only, Minimum age 19)*

To learn more about plan designs and rates visit HawaiiDentalService.com or call 1-844-379-4325.

Section 2 | PERSONS TO BE COVERED

First Name	Last Name	Date of Birth (MM/DD/YYYY)	Relationship to Policyholder (Self, Spouse, or Dependent)	Sex M/F	Disabled Child Y/N
		__/__/____		☐M ☐F	☐Y ☐N
		__/__/____		☐M ☐F	☐Y ☐N
		__/__/____		☐M ☐F	☐Y ☐N
		__/__/____		☐M ☐F	☐Y ☐N
		__/__/____		☐M ☐F	☐Y ☐N
		__/__/____		☐M ☐F	☐Y ☐N

HOW DID YOU HEAR ABOUT THIS PLAN? (Required)

☐ Television ☐ Print Ad ☐ HDS Website ☐ Social Media ☐ Friends/Family ☐ HDS Employee/Dentist/Broker*

**Please provide FULL details below if you were referred to a dental plan by an HDS employee, dentist, or broker:*

☐ **HDS Employee:** First Name: _____ Last Name: _____

☐ **Dentist or Broker:** First Name: _____ Last Name: _____

Office Address (visited): _____

(CONTINUED ON PAGES 2 & 3)

Section 3 | ACCEPTANCE OF TERMS AND CONDITIONS (REQUIRED)

I have read the Terms and Conditions for the HDS Individual Dental Plan. I understand and agree to the benefits, restrictions and other plan terms covered under the HDS Dental Plan. The Terms and Conditions will apply regardless if any dental services have been used. I hereby certify under the penalty of perjury that the information contained in this application is true and complete and choose to enroll the people identified in this application. HDS has the right to deny this application or terminate enrollment if the information is inaccurate or incomplete.

_____ ___ /___ /_____

Responsible Party Signature (Required) **Date (MM/DD/YYYY)**

Section 4 | PAYMENT METHOD SELECTION (REQUIRED)

I elect to make payment by:

☐ Automatic Monthly Deduction from Bank Account (Complete Bank Account Information, **Section 4A**. You must pay the first month's premium by check or money order, payable to Hawaii Dental Service and submit with this application.)

☐ Automatic Monthly Charge by Credit Card (Complete Credit Card Authorization, **Section 4B**)

☐ *Annual Payment by Credit Card (Complete Credit Card Authorization, **Section 4B**)

☐ *Annual Payment by Check (Make payable to Hawaii Dental Service and submit with this application)

*The first year's annual premium equals: Monthly Premium $_____ X _____ # of months remaining in the calendar year

Section 4A MONTHLY BANK DEDUCTION	Complete bank account information below for Monthly Bank Deduction. Attach documentation to validate the account number provided (such as a voided check or account statement). **You must pay the first month's premium by check or money order, payable to Hawaii Dental Service.**

By electing the monthly bank deduction option, I certify that I am the owner of the designated financial account and have authority to direct payments from the account. I authorize HDS to deduct payment of dental benefit premiums from the account with the financial institution indicated. The monthly payment will be automatically deducted on the 23rd or next business day of each month for the next month's premium. I understand that coverage will be granted only if premium payments have been received by HDS. If sufficient funds are not available at the time of deduction, HDS may charge a special handling fee (currently $25.00) in addition to the monthly premium due. I understand that HDS is not required to inform me of any change in the amount of premiums and this authorization will remain in full force and effect until HDS receives written notification of its termination. I understand that HDS and/or the financial institution indicated reserve the right to end this payment plan and my participation therein. I certify the bank account information provided by me is true, correct and complete.

1. Name of Financial Institution (Name of your bank, savings & loan or credit union)	
2. Name as Shown on Bank Account	3. Type of Account (Choose One) ☐ Checking ☐ Savings
4. Financial Institution Routing Number ___ ___ ___ ___ ___ ___ ___ ___ ___	5. Bank Account Number
6. Signature of Bank Account Owner	7. Date (MM/DD/YYYY) ____ /____ /_____

LAST NAME OF RESPONSIBLE PARTY: _____

(SECTION 4B CREDIT CARD PAYMENT ON PAGE 3)

Section 4B CREDIT CARD PAYMENT	Select monthly or annual payment and complete the credit card information below.

By electing the credit card payment option, I certify that I am the cardholder of the designated credit card account and have authority to direct payments on the account. I authorize HDS to charge dental benefit premiums to the credit card account indicated. The monthly payment will be automatically charged on or about the 17th of each month for the following month's premium. I understand that coverage will be granted only if premium payments have been received by HDS. If the payment transaction is dishonored by my credit card issuer, HDS may charge a special handling fee (currently $25.00) in addition to the monthly premium due. I understand that HDS is not required to inform me of any change in the amount of premiums and this authorization will remain in full force and effect until HDS receives written notification of its termination. I will be responsible for informing HDS of any updated card expiration date. I understand that HDS and/or the credit card issuer indicated reserve the right to end this payment plan and my participation therein. I hereby certify the account information provided by me is true, correct and complete.

1. Subscriber or Responsible Party Name

2. Payment Option (Check One)

☐ Automatic Monthly Payment ☐ Annual Payment – Amount $ _____

3. Card Holder's Name	4. Card Holder's Billing Address & Phone Number

5. Card Number

____ ____ ____ ____-____ ____ ____ ____-____ ____ ____ ____-____ ____ ____ ____

6. Expiration Date (MM/YY) ____/____	7. Card Type (Check One) ☐ Visa ☐ MasterCard ☐ Discover
8. Signature of Card Holder	9. Date (MM/DD/YYYY) ____/____/_____

Note: Credit card information received by email or fax will not be processed by Hawaii Dental Service, please mail the entire form to:

Hawaii Dental Service
Attention: IDP Department
700 Bishop Street, Suite 700
Honolulu, HI 96813

HDS USE ONLY							
HDS Group #		*HDS Member ID*		*Entered By*		*Date Entered:*	

2019 HDS Individual Dental Plans

This is an overview of the dental plans offered. See HawaiiDentalService.com for more details.

PLAN NAME	HDS Individual Dental Plan for Children # 2999	HDS Basic Dental Plan # 1059	HDS Classic Dental Plan # 2525		HDS Preferred Dental Plan # 2851		HDS Deluxe Dental Plan # 1061	
Also Available on Healthcare.gov	Healthcare.gov #7060		Healthcare.gov #7010		Healthcare.gov #7020			
PLAN COVERS	**Children Only** maximum age through 25	**Adults Only** minimum age 19	**Children** maximum age through 18	**Adults**	**Children** maximum age through 18	**Adults**	**Children** maximum age through 18	**Adults**
Maximum Out-of-Pocket per calendar year for children OR **Plan Maximum** per calendar year for adults	$350 / child $700 / 2 or more children	$1,000	$350/child $700/2 or more children	$1,000	$350/child $700/2 or more children	$1,000	$350/child $700/2 or more children	$1,000
Diagnostic & Preventive Waiver HDS's payment for Diagnostic & Preventive services will not be deducted from the member's Plan Maximum	N/A	No	N/A	Yes	N/A	Yes	N/A	Yes
Deductible per calendar year, per person	$50/person	$50/person	$50/person	$50/person	$50/person	$50/person	$50/person	$50/person
DIAGNOSTIC & PREVENTIVE CARE **Examinations** – 2 per calendar year **Cleanings** – 2 per calendar year * **Fluoride** – 2 per calendar year through age 18 **Fluoride** (high risk) – 1 per calendar year **Space Maintainers** – through age 18 **Sealants** – through age 18	100%	100%	100%	100%	100%	100%	100%	100%
Bitewing X-rays – 2 per calendar year through age 18; 1 per calendar year for adults	30% 2 per year	50%	30%	50%	30%	50%	100%	100%
Other X-rays – full mouth, once every five years	30%	50%	30%	50%	30%	50%	70%	70%
BASIC CARE **Fillings** --- **Root Canals** **Gum Treatment** (N/A for Basic Plan) **Oral Surgery**	30%	30% 3-month wait period --- 30% 12-month wait period	30%	30% 3-month wait period --- 30% 12-month wait period	30%	50% 3-month wait period --- 50% 12-month wait period	70%	70% 3-month wait period --- 70% 12-month wait period
MAJOR CARE **Crowns and Gold Restorations** **Fixed Bridges & Dentures**	30%	N/A	30%	30% 12-month wait period	30%	50% 12-month wait period	50%	50% 12-month wait period
Orthodontics Some plans cover dependent children through age 25 with $1,000 lifetime max per child. All plans cover dependent children through age 18 when medically necessary.	50% Medically necessary only	N/A	50% Medically necessary only	N/A	50%	N/A	50%	N/A
RATE PER MONTH	$31.20	Starting at $19.90 *Rate per month varies by age*	$31.20	Starting at $22.80 *Rate per month varies by age*	$35.30	Starting at $28.70 *Rate per month varies by age*	$42.20	Starting at $36.30 *Rate per month varies by age*

(*) Additional cleanings included for expectant mothers and diabetic patients.

Dependent children ages 19-25 receive adult benefits.

Please note that as an HDS member, you may visit any licensed dentist, but your out-of-pocket costs may be lower when visiting an HDS participating dentist.

Please consult your dentist or contact HDS Customer Service if you have any questions prior to enrolling.

7/9/2018

2019 Monthly Premium Rates per Person

	HDS Children Only Dental Plan #2999 (maximum age 25)	HDS Basic Dental Plan #1059 (minimum age 19)	HDS Classic Dental Plan #2525	HDS Preferred Dental Plan #2851	HDS Deluxe Dental Plan #1061	Please count only dependent children under age 21 in this section.			
Age	Rate	Rate	Rate	Rate	Rate	Number of Enrollees			Monthly Premium
0 – 20	$31.20	N/A	$31.20	$36.40	$43.50	x	1	=	$
0 – 20	$31.20	N/A	$31.20	$36.40	$43.50	x	2	=	$
0 – 20	$31.20	N/A	$31.20	$36.40	$43.50	x	3 or more	=	$
						Dependent Children under 21 Rate Subtotal (a)			$

	HDS Children Only Dental Plan #2999 (maximum age 25)	HDS Basic Dental Plan #1059 (minimum age 19)	HDS Classic Dental Plan #2525	HDS Preferred Dental Plan #2851	HDS Deluxe Dental Plan #1061	Please include in this section the responsible party and spouse regardless of age, and any dependent children age 21 or older.			
Age	Rate per Person	Rate per Person	Rate per Person	Rate per Person	Rate per Person	Number of Enrollees by Age			Monthly Premium
15 – 20	$31.20	$20.50	$31.20	$36.40	$43.50	x		=	$
21 – 24	$31.20	$20.50	$22.80	$28.70	$37.40	x		=	$
25	$31.20	$20.90	$24.80	$31.20	$40.70	x		=	$
26 – 29	N/A	$20.90	$24.80	$31.20	$40.70	x		=	$
30 – 34	N/A	$21.40	$26.10	$32.70	$41.20	x		=	$
35 – 39	N/A	$21.80	$27.00	$33.80	$41.80	x		=	$
40 – 44	N/A	$22.20	$27.50	$34.40	$42.50	x		=	$
45 – 49	N/A	$22.90	$28.00	$35.10	$44.70	x		=	$
50 – 54	N/A	$23.70	$30.40	$38.10	$47.10	x		=	$
55 – 59	N/A	$24.30	$33.60	$42.20	$52.10	x		=	$
60 – 63	N/A	$25.00	$35.20	$44.20	$54.60	x		=	$
64 +	N/A	$27.30	$36.20	$45.30	$56.00	x		=	$
						Adult Rate Subtotal (b)			$
						Total Monthly Rate *Please add subtotal (a+b)*			$

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HDS
Hawaii Dental Service

We're giving you more to smile about.

Total Health Plus

supplemental benefits designed for members in need of extra care

We just upgraded your dental plan to help you live well and **smile** more.

We understand some people need more oral health services to maintain total body health. That's why we've upgraded your dental plan to include Total Health Plus, a supplemental set of benefits tailored to certain medical conditions or diagnoses.

What can Total Health Plus do for me and my family?

HDS Total Health Plus Benefits provides additional coverage for members with:

- Diabetes
- Cancer
- Oral Cancer
- Stroke & Heart Problems
- Kidney Failure
- Medical Risk for Cavities
- Organ Transplants
- Sjögren's Syndrome — a disorder of the immune system causing dry mouth
- Pregnancy

Designed for Prevention

HDS Total Health Plus gives you access to more services and shares the importance of maintaining good oral health care. This supplemental set of benefits is essential to improving your overall health and is designed to prevent oral disease and tooth decay that accompanies certain medical conditions or diseases. Contact your dentist to see if you qualify for Total Health Plus benefits.

Contact Us

Phone
(808) 529-9248 or call toll-free at 1-844-379-4325

Email
CS@HawaiiDentalService.com

To create and view your account online, visit:
HawaiiDentalService.com

Follow us

HDS Total Health Plus Benefits

Medical Condition or Diagnosis	Benefit	Frequency
Diabetes *(or history of diabetes)*	Cleanings	two additional per year
Cancer *(or history of cancer or undergoing treatment such as chemotherapy or radiation; not including oral cancer)*	Cleanings Fluoride Treatments	two additional per year two additional per year
Oral Cancer *(or history of oral cancer or undergoing treatment for oral cancer)*	Cleanings Fluoride Treatments	two additional per year four additional per year
Sjögren's Syndrome *(or history of Sjögren's Syndrome)*	Cleanings Fluoride Treatments	two additional per year four additional per year
Stroke *(or history of stroke; TIA - Transient Ischemic Attack)*	Cleanings	two additional per year
Heart Attack, Congestive Heart Failure *(or history of heart attack; MI - Myocardial Infarction)*	Cleanings	two additional per year
Kidney Failure *(or history of renal failure or dialysis)*	Cleanings	two additional per year
Organ Transplants *(or history of organ transplants)*	Cleanings	two additional per year
Pregnancy *(expectant mothers)*	Cleanings	one additional per year
Medical Risk for Cavities	Fluoride Treatments	three additional per year

All benefits listed above are covered at 100%.

DELTA DENTAL

HDS
Hawaii Dental Service

Effective January 1, 2019

Terms & Conditions for:
- **HDS Individual Dental Plan for Children**
- **HDS Basic Dental Plan**
- **HDS Classic Dental Plan**
- **HDS Preferred Dental Plan**
- **HDS Deluxe Dental Plan**

Thank you for choosing HDS as your dental plan. This document lists the terms and conditions of your dental plan. Please read this document and keep it in a safe place for reference.

"You" refers to the person who is the subscriber or Responsible Party of this policy.

Your Application and "How to Use Your Dental Plan" brochure are part of this plan's Terms and Conditions.

Eligibility Guidelines

Resident of the State of Hawaii
Enrollment is for a minimum of 12 months
Eligible family members include:
- You and your:
- Spouse, partner or reciprocal beneficiary
- Dependent children under age 26 will be automatically terminated from the plan on December 31 the year in which they turn age 26. Dependents include:
    - Biological child, stepchild, foster child, adopted child and child placed under legal guardianship
- Disabled dependents age 26 and older who are unmarried and incapable of supporting themselves because of physical or mental incapacity that began before age 26 may continue to be enrolled under the plan

Responsible Party

HDS allows you to enroll your immediate family members only (no dental coverage for yourself) and you will be considered the Responsible Party. HDS will assume you will have financial responsibility to pay for the dental premiums. Family members eligible to enroll are:
- Spouse, partner, or reciprocal beneficiary
- Dependent children as stated above

Effective Date (Start Date) of This Plan

A completed HDS Application (or online enrollment) along with premium payment must be received by the 25th of the month in order for benefits to start the 1st of the next month. For example: Applications received on January 25th will be effective February 1st. Applications received on January 26th will be effective March 1st.

Monthly Premium Rates
Monthly premium rates are determined by the age of each enrollee on January 1 of each year and are subject to change each January 1. For all the plans except the HDS Basic Dental Plan, the first three children under age 21 will be charged a premium per child. Additional children will not be charged a premium. Changes in enrollment may adjust your premium rates.

Paying for Your Dental Plan
HDS provides you three options to pay for your dental plan: annual payment, monthly payment by bank account and monthly payment by credit card. Whichever option you choose, your dental coverage will be granted only if premium payments have been received in full by HDS.

- Annual Payment – paid by check or credit card before the start date of the plan. Your first year's premiums are calculated for the remaining number of months in the current calendar year multiplied by the appropriate monthly premium rate.

- Monthly Payment by Bank Account – the first month's payment must be submitted before the start date of the plan. The initial payment can be made by check, money order or credit card. HDS will automatically deduct future payments from the bank account you designate. Monthly payments will be deducted on the 23rd or next business day of each month for the next month's premium. For example: The premium payment for August will be automatically deducted on July 23rd.

- Monthly Payment by Credit Card – the first month's payment must be submitted before the start date of the plan. HDS will automatically process future payments from the credit card account you designate. Monthly payments will be charged on or around the 17th of each month, for the next month's premium. For example: The premium payment for August will be automatically charged on or around July 17th.

  All credit card payments are processed through HDS's credit card processor. You will be responsible for notifying HDS 30 days in advance of any update to the credit card expiration date.

HDS will process your premium payment using the account information (bank or credit card account) authorized by you or the account owner.

Dishonored Requests for Automatic Payments/Special Handling Fees
If you do not have enough money in your account at the time of deduction or your credit card issuer or network does not honor your payment, we:

a. have the right to collect a special handling fee (currently $25).
b. have the right to collect the amount from you via other approved payment methods (cash, check, credit card, money order or cashier's check).
c. will suspend benefits until all premiums and special handling fees have been paid in full.
d. may terminate your dental plan for non-payment.

Late Fee
A late fee (currently $15.00) may be applied to your account for monthly or annual premium payments which are not received by the due date.

Changing Payment Options or Bank/Credit Card Accounts for Automatic Monthly Payments
Payment options may be changed at any time. Submit the new account information to HDS by the 15th day of the month to be effective for your next payment.

Renewal Terms
- This plan renews every January 1. Enrollment in the plan is subject to annual renewal.
- Before December 1 of each year, HDS will notify you of any changes in premium rates, benefits and/or other plan terms for the next calendar year.
- Unless you choose to terminate your plan, your enrollment will be renewed automatically for the next calendar year. New premium rates, benefits and/or plan terms specified in the notice will apply.

Terminating Your Dental Plan
All requests for termination are effective on the last calendar day of the month which HDS received the request. HDS will accept written, email and phone requests to our Customer Service department from the subscriber only. Any overpayment resulting from an approved termination request will be refunded.

Retroactive terminations **will not** be permitted. If you terminate your dental plan within 12 months of enrollment, you may not re-enroll until after 90 days from your date of termination. Any re-enrollment will be considered a new enrollment; therefore, any waiting periods and deductibles will apply as new.

Email Notifications
By providing an email address, you agree to receive communications regarding your policy, premium payments or benefits electronically.

Maintaining Accurate Information
It is your sole responsibility to ensure that your contact and account information are current and accurate. This will include information such as your name, address, phone number, email address and bank account or credit card information.

Amendments to Terms & Conditions
HDS reserves the right to change these Terms and Conditions at any time.

Questions Regarding Your Plan
If you have any questions regarding the plan benefits and these Terms and Conditions, please call our Customer Service department at 529-9248 or toll-free at 1-844-379-4325 or email CS@HawaiiDentalService.com.

For matters pertaining to premium payments, please call our Billing department at 529-9313 or toll-free at 1-800-232-2533, extension 313 or email HDSIndividualDentalPlan@HawaiiDentalService.com.

Once enrolled, you may access your Individual Dental Plan account information on our website at HawaiiDentalService.com. Go to “Members > My Individual Plan Account”.

Notice of Non-Discrimination & Language Assistance

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

HDS provides 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, other formats)

HDS provides 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 1-844-379-4325, TTY: 711.

If you believe that HDS 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 with:

Civil Rights Coordinator: Director of Compliance
700 Bishop Street, Suite 700, Honolulu, HI 96813-4196
Telephone Number: 1-866-505-9227 Fax: (808) 599-4808
Email: HDScompliance@hawaiidentalservice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-379-4325; TTY: 711
(Ilocano) PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-844-379-4325 TTY: 711
(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-379-4325 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。 1-844-379-4325 TTY: 711 . まで、お電話にてご連絡ください。
(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 1-844-379-4325 TTY: 711.
(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-379-4325 TTY: 711 번으로 전화해 주십시오.
(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-379-4325 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 1-844-379-4325 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: 1-844-379-4325 TTY: 711
(Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-379-4325 TTY: 711
(Trukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-844-379-4325 TTY: 711
(Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1-844-379-4325 TTY: 711
(Micronesian-Pohnpeian) Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-844-379-4325 TTY: 711
(Bisayan) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1-844-379-4325 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 1-844-379-4325 TTY: 711
(Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-379-4325 TTY: 711