



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 [bswh.swhp.org](http://bswh.swhp.org), or call 1-844-843-3229. 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 [cio.cms.gov](http://cio.cms.gov) or call 1-844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:												
What is the overall <a href="#">deductible</a> ?	<table border="1"> <tr> <td>INN</td> <td>Tier 1</td> <td>Tier 2</td> <td>Tier 3</td> </tr> <tr> <td>EE</td> <td>\$1,500</td> <td>\$3,000</td> <td>\$5,000</td> </tr> <tr> <td>EF</td> <td>\$3,000</td> <td>\$6,000</td> <td>10,000</td> </tr> </table> <p>Does not apply to <a href="#">preventive care</a>.</p>	INN	Tier 1	Tier 2	Tier 3	EE	\$1,500	\$3,000	\$5,000	EF	\$3,000	\$6,000	10,000	Generally, you must pay all of the costs from <a href="#">providers</a> 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> . There is an aggregate <a href="#">deductible</a> for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children).
INN	Tier 1	Tier 2	Tier 3											
EE	\$1,500	\$3,000	\$5,000											
EF	\$3,000	\$6,000	10,000											
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you have not 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 <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://.healthcare.gov/coverage/preventive-care-benefits/">.healthcare.gov/coverage/preventive-care-benefits/</a> .												
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.												
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<table border="1"> <tr> <td>INN</td> <td>Tier 1</td> <td>Tier 2</td> <td>Tier 3</td> </tr> <tr> <td>EE</td> <td>\$3,950</td> <td>\$6,750</td> <td>Unlimited</td> </tr> <tr> <td>EF</td> <td>\$7,900</td> <td>\$13,500</td> <td>Unlimited</td> </tr> </table>	INN	Tier 1	Tier 2	Tier 3	EE	\$3,950	\$6,750	Unlimited	EF	\$7,900	\$13,500	Unlimited	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. There is an embedded <a href="#">out-of-pocket limit</a> for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children). For Tier 1 and Tier 2, deductible included in <a href="#">out-of-pocket</a> max.
INN	Tier 1	Tier 2	Tier 3											
EE	\$3,950	\$6,750	Unlimited											
EF	\$7,900	\$13,500	Unlimited											
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .												
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://bswh.swhp.org/">bswh.swhp.org/</a> or call 1-844-843-3229 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Preferred Network. You pay more if you use a <a href="#">provider</a> in In-Network. 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.												
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		Tier 1: Preferred Network PROVIDER (You will pay the least)	Tier 2: Network PROVIDER	Tier 3: Out-of-Network PROVIDER (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	For prior authorization requirements see <a href="https://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> . Services that are not <a href="#">preauthorized</a> will be denied.
	Imaging (CT/PET scans, MRIs)	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	For prior authorization requirements see <a href="https://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> . Services that are not <a href="#">preauthorized</a> will be denied.
If you need drugs to treat your illness or condition	Tier 1: Preferred Generic Drugs	10% after <a href="#">deductible</a>	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	<a href="#">Copays</a> are per 30-day supply. 90-day supply is available if a maintenance drug is obtained through a Baylor Scott & White

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Preferred Network PROVIDER (You will pay the least)	Tier 2: Network PROVIDER	Tier 3: Out-of-Network PROVIDER (You will pay the most)	
More information about <a href="#">prescription drug coverage</a> is available at <a href="http://bswh.swhp.org/pharmacy-information">bswh.swhp.org/pharmacy-information</a> .	Tier 2: Preferred Brand Name Drugs	10% after <u>deductible</u>	10% after <u>deductible</u>	50% after <u>deductible</u>	<p>pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member.</p> <p>The ACA Preventive Drugs are the \$0 cost share drugs based on Health Care Reform regulations.</p> <p>You have access to Baylor Scott &amp; White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more.</p> <p>Some drugs may require prior authorization. 30-day supply only.</p>
	Tier 3: Non-Preferred Brand Name Drugs	10% after <u>deductible</u>	10% after <u>deductible</u>	50% after <u>deductible</u>	
	Tier 4: <a href="#">Specialty Drugs</a> and Oral Chemotherapy Drugs	10% after <u>deductible</u>	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services that are not <a href="#">preauthorized</a> will be denied.
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% after <u>deductible</u>	10% after <u>deductible</u>	10% after <u>deductible</u>	Emergency transportation includes ground and air ambulance.
	<a href="#">Emergency medical transportation</a>	10% after <u>deductible</u>	10% after <u>deductible</u>	10% after <u>deductible</u>	
	<a href="#">Urgent care</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	50% after <u>deductible</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	<p>For prior authorization requirements see <a href="http://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a>.</p> <p>Services that are not</p>
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Preferred Network PROVIDER (You will pay the least)	Tier 2: Network PROVIDER	Tier 3: Out-of-Network PROVIDER (You will pay the most)	
					<a href="#">preauthorized</a> will be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services that are not <a href="#">preauthorized</a> will be denied.
	Inpatient services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
If you are pregnant	Office visits	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	No charge for prenatal visits for Tiers 1 and 2.
	Childbirth/delivery professional services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services that are not <a href="#">preauthorized</a> will be denied.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	120 visit limit per calendar year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Rehabilitation services</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per calendar year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Habilitation services</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per calendar year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Skilled nursing care</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	120 visit limit per calendar year. Services that are not <a href="#">preauthorized</a> will be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Preferred Network PROVIDER (You will pay the least)	Tier 2: Network PROVIDER	Tier 3: Out-of-Network PROVIDER (You will pay the most)	
	<a href="#">Durable medical equipment</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Hospice services</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services that are not <a href="#">preauthorized</a> will be denied.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Cosmetic surgery	• Non-emergency care when traveling outside U.S.	• Routine foot care
• Dental care (Adult)	• Routine eye care (Adult)	• Weight loss programs
• Long-term care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
• Acupuncture (20 visit limit per calendar year)	• Hearing aids (1 device every 36 months)
• Bariatric surgery (Tier 1 and Tier 2 only)	• Infertility treatment (Limited to \$7,500 medical and \$7,500 pharmacy lifetime max)
• Chiropractic care (20 visit limit per calendar year)	• Private-duty nursing (120 visit limit per calendar year)

**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: Optum, [adminservices.optumhealthfinancial.com](mailto:adminservices.optumhealthfinancial.com), or call 866-301-6681; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or call 1-866-444-EBSA (3272). 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 [HealthCare.gov](http://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: Scott and White Health Plan, visit [bswh.swhp.org/](http://bswh.swhp.org/), or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or call 1-866-444-EBSA (3272).

**Does this plan 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 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 1-844-843-3229.

————— *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](#) \$1,500
- [Specialist copayment](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

**Sample Care Costs**

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

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$150
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,650</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

**Sample Care Costs**

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

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,160</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) 10%
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

**Sample Care Costs**

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination Notice

---



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

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

Scott & White Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- 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 the Scott & White Care Plans Compliance Officer at 1-214-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org)

If you believe that Scott & White Care Plans 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:

Scott & White Care Plans, Compliance Officer  
1206 West Campus Drive, Suite 151  
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or <https://app.mycompliancereport.com/report.aspx?cid=swhp>

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer 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, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.



**English:**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

**Spanish:**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (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 1-800-321-7947 (TTY: 711).

**Chinese:**

注意: 如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947(TTY:711)。

**Korean:**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

**Arabic:**

هاتف الصم والبكم: 711. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم 800-321-7947-1)

**Urdu:**

کریں. (TTY: 711) 1-800-321-7947 خیردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال

**Tagalog:**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

**French:**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

**Hindi:**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

**Persian:**

فراهم می باشد. با (TTY: 711) 1-800-321-7947 تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

**German:**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

**Gujarati:**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

**Russian:**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 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。1-800-321-7947 (TTY:711)まで、お電話にてご連絡ください。

**Laotian:**

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອ ວ່າ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະ ສະ ບັ ດ ທ່ານ, ແມ່ນ ມີ ພ້ອມ ໃຫ້ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).