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, call 844-633-5325 or visit us at [BSWHealthPlan.com](http://www.bswhealthplan.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 [HealthCare.gov/sbc-glossary](http://www.HealthCare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall <strong>deductible</strong>?</td>
<td>$2,500 per member / $5,000 per family for a <strong>participating provider</strong> and $5,000 per member / $10,000 per family for a <strong>non-participating provider</strong>.</td>
<td>Generally, you must pay all of the costs from <strong>providers</strong> up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there services covered before you meet your <strong>deductible</strong>?</td>
<td>Yes. Preventive care and Affordable Care Act (ACA) preventive drugs are covered before you meet your <strong>deductible</strong>.</td>
<td>This <strong>plan</strong> covers some items and services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without <strong>cost sharing</strong> and before you meet your <strong>deductible</strong>. See a list of covered <strong>preventive services</strong> at <a href="http://www.HealthCare.gov/coverage/preventive-care-benefits">HealthCare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td>Are there other <strong>deductibles</strong> for specific services?</td>
<td>No</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services.</td>
</tr>
<tr>
<td>What is the <strong>out-of-pocket limit</strong> for this <strong>plan</strong>?</td>
<td>$5,000 per member / $10,000 per family for a <strong>participating provider</strong> and $15,000 per member / $30,000 per family for a <strong>non-participating provider</strong>.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay in a year for covered services. If you have other family members in this <strong>plan</strong>, they have to meet their own <strong>out-of-pocket limits</strong> until the overall family <strong>out-of-pocket limit</strong> has been met.</td>
</tr>
<tr>
<td>What is not included in the <strong>out-of-pocket limit</strong>?</td>
<td><strong>Premiums</strong>, <strong>balance billing</strong> charges, and health care this <strong>plan</strong> doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out–of–pocket limit</strong>.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. See <a href="http://www.bswhealthplan.com/Pages/Provider.aspx">https://www.bswhealthplan.com/Pages/Provider.aspx</a> or call 844-633-5325 for a list of <strong>network providers</strong>.</td>
<td>This <strong>plan</strong> uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the <strong>plan’s network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the <strong>provider’s charge</strong> and what your <strong>plan</strong> pays (<strong>balance billing</strong>). Be aware, your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No</td>
<td>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider (You will pay the least)</th>
<th>Non-Participating Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Adult: No charge for the first non-preventive sick visit in the plan year. $30 <strong>copayment</strong> per visit for subsequent visits in that plan year, <strong>deductible</strong> does not apply. Pediatric: No charge per visit.</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 <strong>copayment</strong> per visit, <strong>deductible</strong> does not apply</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, <strong>deductible</strong> does not apply</td>
<td>50% after deductible</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>No charge</td>
<td>50% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% of charges</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Affordable Care Act (ACA) preventive drugs</td>
<td>No charge, <strong>deductible</strong> does not apply</td>
<td>50% after deductible</td>
<td><strong>Copayments</strong> are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 <strong>copayments</strong> if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. <strong>Specialty drugs</strong> limited to a 30-day supply. <strong>Formulary</strong> insulin prescriptions</td>
</tr>
<tr>
<td></td>
<td>Tier 1: Preferred generic drugs</td>
<td>$20 <strong>copayment</strong> per prescription</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred brand name drugs</td>
<td>$65 <strong>copayment</strong> per prescription</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3: Non-preferred generic drugs and non-</td>
<td>$120 <strong>copayment</strong> per prescription</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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<td>-------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>preferred brand name drugs</td>
<td>Tier 1: 20% of charges</td>
<td>50% after deductible</td>
<td>have a maximum copayment of $25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the applicable brand name drug copayment plus the difference in cost of the brand name drug and generic equivalent drug.</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs:</td>
<td>Tier 2: 20% of charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs:</td>
<td>Tier 3: 30% of charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$500 copayment per visit, plus 20% of charges</td>
<td>Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$500 copayment per service, plus 20% of charges</td>
<td>$500 copayment per service, plus 20% of charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Outpatient services</td>
<td>Adult: $30 copayment per visit, 20% after deductible for all other outpatient services Pediatric: No charge per visit</td>
<td>Failure to obtain preauthorization of partial hospitalization benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Failure to obtain preauthorization of residential treatment benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$30 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
<td>Cost sharing does not apply for preventive services. 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).</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Inpatient care for the mother and newborn child in a health care facility is covered for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean section.</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Limited to 60 visits per plan year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$30 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
<td>Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. Limit is combined for physical therapy, occupational therapy, and speech therapy. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$30 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-Participating Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Limited to 25 days per plan year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% after deductible</td>
<td>50% after deductible</td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>50% after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>
### 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 | - Infertility treatment | - Routine eye care (Adult and Child) |
| - Bariatric surgery | - Long-term care | - Routine foot care |
| - Cosmetic surgery | - Non-emergency care when traveling outside the U.S. | - Weight loss programs |
| - Dental care (Adult and Child) | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.) |
|---|---|---|
| - Chiropractic care (Limited to 35 visits per plan year) | - Hearing aids (Limited to one device per ear every 3 years for members through the age of 18) | - Private duty nursing when medically necessary and preauthorized (Limitations apply when used under Home Health Care) |

### 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: Baylor Scott & White Insurance Company at 844-633-5325 or BSWHealthPlan.com; Department of Labor’s Employee Benefits Security Administration at 866-444-EBSA (3272) or DOL.gov/ebsa/healthreform. 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 or call 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: Baylor Scott & White Insurance Company at 844-633-5325 or BSWHealthPlan.com; Department of Labor’s Employee Benefits Security Administration at 866-444-EBSA (3272) or DOL.gov/ebsa/healthreform; Texas Department of Insurance at 800-578-4677 or TDI.texas.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:**

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**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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$2,500</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$60</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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:

| Deductibles | $2,500 |
| Copayments | $10 |
| Coinsurance | $1,800 |

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $4,370

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:

| Deductibles | $800 |
| Copayments | $700 |
| Coinsurance | $0 |

What isn’t covered

| Limits or exclusions | $20 |

The total Joe would pay is $1,520

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:

| Deductibles | $1,100 |
| Copayments | $1,000 |
| Coinsurance | $0 |

What isn’t covered

| Limits or exclusions | $20 |

The total Mia would pay is $2,100

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 1-844-633-5325 (TTY: 711).

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

Baylor Scott & White Insurance Company:

- 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 Baylor Scott & White Insurance Company Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Insurance Company 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:

Baylor Scott & White Insurance Company, Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report?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.

BSWIC_Nondiscrimination_Notice_12/2021
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Vietnamese:

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 1-844-633-5325 (TTY：711)。

Korean:

Arabic:
يرجى الاتصال على 1-844-633-5325 (TTY: 711) إذا كنت تتحدث اللغة العربية.

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، آپ کو زبان کی خدمات مفتوح دستیاب بیان کریں (711).

Tagalog:

French:

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
فرآهنمی می باشد. با (711) 1-844-633-5325 تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تجهیزات زبانی بصورت رایگان برای شما تجربه می کنند.

German:

Gujarati:
સુચના: તમે ગુજરાતી બોલતા હોય તો તમારે ભાષા સહાય સેવાઓ મળી શકે છે. ફોન કરો 1-844-633-5325 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (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。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
โปรดติดต่อกับ 1-844-633-5325 (TTY: 711) ถ้าคุณพูดภาษาลาติว.