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 https://www.bswhealthplan.com/Group/Pages/Default.aspx - small. 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 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 deductible?</td>
<td>$7,300 per member / $14,600 per family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and certain preventive drugs are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at HealthCare.gov/coverage/preventive-care-benefits.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$9,100 per member / $18,200 per family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.bswhealthplan.com/Pages/Provider.aspx">https://www.bswhealthplan.com/Pages/Provider.aspx</a> or call 844-633-5325 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</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>What You Will Pay</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult: No charge for the first non-preventive sick visit in the plan year. $25 copayment per visit for subsequent visits in that plan year, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pediatric: No charge, deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>0% after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% after deductible</td>
<td>Not covered</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, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Generic drugs (Tier 1)</td>
<td>$15 copayment per prescription, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$55 copayment per prescription, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$150 copayment per</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [https://www.bswhealthplan.com/Pages/Pharmacy.aspx](https://www.bswhealthplan.com/Pages/Pharmacy.aspx).

Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for three (3) copayments 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. **Specialty drugs** limited to a 30-day supply. **Formulary** insulin prescriptions have a maximum copayment.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$750 copayment per visit after deductible</td>
<td>$750 copayment per visit after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$750 copayment per service after deductible</td>
<td>$750 copayment per service after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$60 copayment per visit, deductible does not apply</td>
<td>$60 copayment per visit, deductible does not apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Adult: $25 copayment per office visit, 0% after deductible for all other outpatient services. Pediatric: No charge, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

- Specialty drugs (and oral anticancer medications) (Tier 4) prescription, deductible does not apply

- Specialty drugs (and oral anticancer medications) (Tier 4) $500 copayment per prescription, deductible does not apply

- Specialty drugs (and oral anticancer medications) (Tier 4) Not covered

- Specialty drugs (and oral anticancer medications) (Tier 4) of $25 per prescription per 30-day supply. Certain preventive drugs are covered at no charge and are not subject to the deductible. Tiers 2 - 4 may include brand and generic drugs.

- Specialty drugs (and oral anticancer medications) (Tier 4) Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

- Specialty drugs (and oral anticancer medications) (Tier 4) Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.

- Specialty drugs (and oral anticancer medications) (Tier 4) None

- Specialty drugs (and oral anticancer medications) (Tier 4) None

- Specialty drugs (and oral anticancer medications) (Tier 4) Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

- Specialty drugs (and oral anticancer medications) (Tier 4) Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

- Specialty drugs (and oral anticancer medications) (Tier 4) 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
<table>
<thead>
<tr>
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<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
<td>SBC (i.e., ultrasound).</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></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>
</tr>
<tr>
<td>Home health care</td>
<td>0% after deductible</td>
<td>Not covered</td>
<td>Limited to 60 visits per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. The limit is combined for physical therapy, occupational therapy, speech therapy, and chiropractic care. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>0% after deductible</td>
<td>Not covered</td>
<td>Limited to 25 days per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>0% after deductible</td>
<td>Not covered</td>
<td>Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>0% after deductible</td>
<td>Not covered</td>
<td>Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$60 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

If you need help recovering or have other special health needs
- **Home health care**
  - Network Provider: 0% after deductible
  - Out-of-Network Provider: Not covered
  - Limitation: Limited to 60 visits per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

**Rehabilitation services**
- Network Provider: $25 copayment per visit, deductible does not apply
- Out-of-Network Provider: Not covered
- Limitation: Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. The limit is combined for physical therapy, occupational therapy, speech therapy, and chiropractic care. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

**Habilitation services**
- Network Provider: $25 copayment per visit, deductible does not apply
- Out-of-Network Provider: Not covered

**Skilled nursing care**
- Network Provider: 0% after deductible
- Out-of-Network Provider: Not covered
- Limitation: Limited to 25 days per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

**Durable medical equipment**
- Network Provider: 0% after deductible
- Out-of-Network Provider: Not covered
- Limitation: Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

**Hospice services**
- Network Provider: 0% after deductible
- Out-of-Network Provider: Not covered
- Limitation: Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.

**Children’s eye exam**
- Network Provider: $60 copayment per visit, deductible does not apply
- Out-of-Network Provider: Not covered
- Limitation: Limited to one eye exam per plan year.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>$60 copayment per pair, deductible does not apply</td>
<td>Not covered</td>
<td>Limited to one pair of glasses per plan year.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):

- Chiropractic care (Included in Rehabilitation Services and Habilitation Services)
- Hearing aids (Limited to one device per ear every 3 years)
- 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 Health Plan 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 Health Plan 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 1-800-578-4677 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:


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</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$7,300</td>
<td>$7,300</td>
<td>$7,300</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>$60</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>Hospital (facility) copayment</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</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:

| Cost Sharing | Deductibles | $7,300 |
| Copayments | $10 |
| Coinsurance | $0 |

What isn’t covered: $60

The total Peg would pay is: $7,370

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:

| Cost Sharing | Deductibles | $900 |
| Copayments | $800 |
| Coinsurance | $0 |

What isn’t covered: $20

The total Joe would pay is: $1,720

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (X-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $2,800

In this example, Mia would pay:

| Cost Sharing | Deductibles | $2,100 |
| Copayments | $300 |
| Coinsurance | $0 |

What isn’t covered: $0

The total Mia would pay is: $2,400

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 Health Plan 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 Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & White Health Plan:

• 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 Health Plan Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Health Plan 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 Health Plan, 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.
English:
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：如果您使用繁體中文，可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY: 711)。

Korean:

Arabic:
)رﻗﻢ 844-633-5325-1.ﻣﻠﺤﻮظﺔ: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفّرة لك بالمجمل. اتصل برقم 1-844-633-5325 (رقم)

Urdu:
ﺧﺒﺮدار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی خدمات مفت دستیابی پین۔ کال

Tagalog:

French:

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

Persian:
فراهم می یاد دای (111) 711، 844-633-5325 تاماس یگیورید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

German:

Gujarati:
સ્વાગત માટે: જો તમે ગુજરાતી બોલતા હો તો તમારા માટે મફત ભાષા સહાય સેવાઓ છે. 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:
ປະຊາບ: ພ້ອມໝວຍ ດາວ ມວນ ບໍ່ ອາວ ວຽງ ລາວ, ຜົນໃຊ້ ເປັນ ຢ້າງ່ຽວ ເຊອກສ່ຽງ ໃຊ້ ສັງ ມັນ ມາ ບໍ່ຝ່າຍ ສາມີ ບາງ. ແລ່نك 1-844-633-5325 (TTY:711).