Summary of Benefits and Coverage (SBC)

Frequently Asked Questions	In-Network Benefit	Out-of-Network Benefit	Limitations and Exceptions
What is the overall deductible?	Individual: $1,000 Family: $2,000	Individual: $1,400 Family: $2,800	The Out-of-Network deductible will accrue to the In-Network deductible. However, the In-Network deductible will NOT accrue to the Out-of-Network deductible. Covered expenses incurred during any calendar year and applied toward satisfaction of a covered family member's individual calendar year deductible will be accumulated toward the Family Limit. The family deductible is accumulative. Once the family deductible has been satisfied, it will not apply for any other family member's charges. The calendar year deductible will be waived for the new calendar year for a hospital confinement spanning the end of one calendar year and the beginning of the next calendar year. *Eligible in-network preventive/wellness benefits and preferred lab benefits pay at no cost share to the covered individual.*
Are there other deductibles for specific services?	No	Facility Inpatient: Yes $100	In addition to the plan's deductible, there is also a hospital admission copay. A $100 per day copay will apply to all Out-of-Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care.
Is there an out-of-pocket limit on my expenses?	Individual: $3,000 Family: $6,000	No	Once the deductibles and maximum Out-of-Pocket amount is satisfied per individual, the plan pays 100% of eligible charges. The family Out-of-Pocket is accumulative. Once the family Out-of-Pocket amount has been satisfied, it will not apply for any other family member's charges. Amounts used to satisfy the Out-of-Pocket for In-Network and Out-of-Network are separate and do not accumulate towards one another.
What is not included in the out-of-pocket limit?	*See Limitations and Exceptions*	*See Limitations and Exceptions*	The following do not apply towards the Out-of-Pocket: Penalties for failure to follow required Pre-authorization procedures, ineligible charges, charges for treatment of morbid obesity, charges from a chiropractor, charges that exceed reasonable and customary, fees, and charges which exceed the Plan's maximum benefit. *Ineligible charges do not accumulate toward meeting your Deductible or Out-of-Pocket amount.*
Is there a maximum out-of-pocket limit (MOOP) on all my expenses?	Individual: $6,600 Family: $13,200	No	
Does this plan use a network of providers?	Yes	N/A	Go to tmlhealthbebefits.org or call (800) 282-5385 for a list of participating providers. Your deductible, out-of-pocket expenses, and benefit percentage will be different for In-Network and Out-of-Network services.
Do I need a referral to see a specialist?	No	No	This plan does not require referrals. You have the option to choose any provider.
What is my copayment?	Office Visit: $20	N/A	The Office Visit copay includes: Physician office visits, consultations, infusions and injections. The Office Visit copay does not include Genetic/Genomic testing which is subject to deductible and coinsurance. Specialty drugs administered in a clinical setting are subject to Pre-Authorization requirements and the separate prescription copay. Please refer to the Pre-Authorization Requirements section in your Medical Book. See information below regarding Teladoc copays.
Is there an overall annual limit on what the plan pays?	No	No	This plan does not have an annual limit for all benefits combined. The plan does have some limits on lifetime and calendar year benefits for specific conditions and/or treatments, as indicated.
Are there services this plan does not cover?	Yes	Yes	Please refer to the General Exclusions or Limitations section and the definition of Unproven Medical Procedures/Treatment in the plan document.

Common Medical Event	Services You May Need	In-Network Benefit	Out-of-Network Benefit	Limitations, Exceptions and Exclusions
If you visit a health care provider's office or clinic	Primary care or Specialist visit to treat an injury or illness	100% after $20 copay deductible waived	60% after deductible up to R&C	The office visit copay includes charges for office visits, consultations, infusions and injections. For maternity the copay will only apply to the initial visit. The Office Visit copay does not include Genetic/Genomic testing which is subject to deductible and coinsurance. Specialty drugs administered in a clinical setting are subject to Pre-Authorization requirements and the separate prescription copay. Please refer to the Pre-Authorization Requirements section in your Medical Book.
	All other Physician Services	80% after deductible	60% after deductible up to R&C	Services rendered by an Out-of-Network provider are subject to out of network deductibles and out of pocket amounts as well as Reasonable and Customary limits on billed charges. Specialty drugs administered in a clinical setting are subject to Pre-Authorization requirements and the separate prescription copay. Please refer to the Pre-Authorization Requirements section in your Medical Book.
	Teladoc Medical Consult	100%	n/a	Contact Teladoc at 800-TELADOC or visit www.teladoc.com.
	Teladoc Initial Visit for Behavioral Health Services with an MD	100% after $20 copay	n/a	
	Teladoc Follow Up Visit for Behavioral Health Services	100% after $20 copay	n/a	
	Teladoc Psychotherapy Visit	100% after $20 copay	n/a	
	Teladoc Dermatology Consult	100% after $20 copay	n/a	
	Preventive care/screening/immunization	100% deductible waived	60% after deductible up to U&R	**Preventive/Routine Care Benefit** The following will be processed for in-network reimbursement at 100% of in-network allowable. Out-of-Network provider eligible billings will be subject to Reasonable and Customary (R&C) charges and are subject to the Out-of-Network deductible and benefit percentage. To be considered as an eligible preventive/routine care benefit, the provider's bill must designate or outline a routine diagnosis code. This benefit excludes coverage for virtual colonoscopies. The following preventive/routine care benefits includes but is not limited to: • Routine Physical • Well Baby and Well Child Visits • Vision Exam (excluding refractions) • PAP Test and Office Visit • Breast cancer annual chemoprevention for women at high risk • Genetic Counseling for BRCA testing • BRCA testing for women with or without a history of BRCA related cancer • Routine Hearing Exams • Routine Venipuncture • General Health Panel • Mammograms • Prostate Specific Antigen (PSA) • Coronary Risk Profile (lipid panel) • Urinalysis • (TB) Tuberculosis test • Autism Screening – eighteen (18) and twenty-four (24) months of age • Developmental Screening for Children under age three (3) • Handling of specimen to/from physician's office to a laboratory • Occult Stool Test • Examination for the detection of skin cancer • Chest X-Ray (front & lateral) • ECG (electrocardiogram) • Digital Rectal Exam • Skin Cancer Counseling
If you visit an urgent care clinic	Urgent care visit to treat an injury or illness	80% after deductible	60% after deductible up to R&C	Urgent Care Services billed on a UB will be processed under Urgent Care benefit. Urgent Care Services billed on a HCFA will be processed under Hospital Benefit. Specialty drugs administered in a clinical setting are subject to Pre-Authorization requirements and the separate prescription copay. Please refer to the Pre-Authorization Requirements section in your Medical Book.

Common Medical Event	Services You May Need	In-Network Benefit	Out-of-Network Benefit	Limitations, Exceptions and Exclusions
If you have a test	Diagnostic test (x-ray, blood work)	80% after deductible	60% after deductible up to R&C	Preferred Lab will be covered at 100% deductible waived In-Network and includes lab expenses from a Preferred Lab Provider and Preferred Lab drawing site. Eligible in-network preventive/routine benefits and preferred lab benefits pay at no cost share to the covered individual. If lab services are not received at a Preferred Lab drawing site, any physician professional fees billed will be payable as a "physician all other service". Genetic/Genomic testing is subject to deductible and coinsurance.
	Imaging (CT/PET scans, MRIs)	80% after deductible	60% after deductible up to R&C	Refer to Pre-authorization Requirements.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at tmlhealthbenefits.org.**	Generic drugs	Preferred Pharmacy*: $5 up to thirty (30) day supply Retail All other Network Pharmacies: $10 up to thirty (30)-day supply Retail		Specialty drugs administered in a clinical setting are subject to Pre-Authorization requirements and the applicable copay. Please refer to the Pre-Authorization Requirements section in your Medical Book. Refer to your Prescription Schedule of Benefits for more information regarding your Prescription Drug Plan, including copays, limitations, and exclusions.
	Best Brand/Formulary List	Preferred Pharmacy*: $38 up to thirty (30 day supply Retail All other Network Pharmacies: $57 up to thirty (30)-day supply Retail		
	Non-Best Brand/Non-Formulary List	Preferred Pharmacies*: $60 up to a thirty (30) day supply Retail All other Network Pharmacies: $90 up to thirty (30)-day supply Retail		
	Specialty drugs	$100 per thirty (30) day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	80% after deductible	60% up to R&C	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Out-of-Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Review the Pre-authorization Requirements.
	Physician/surgeon fees	80% after deductible	60% after deductible up to R&C	
If you need immediate medical attention	Emergency room services (Emergent/ Urgent)	80% after deductible	80% after deductible	All emergency Room Facility charges are subject to a $200 facility copay. The ER copay applies to the Out-of-Pocket. The Emergency Room copay is waived if admitted. The copay also applies to emergent/immediate care. Please refer to the definitions in the plan document for what is considered emergent/immediate care.
	Emergency room services (Non-Emergent/ Non-Urgent)	80% after deductible	60% after deductible	
	Emergency medical transportation	80% deductible waived	80% deductible waived	Limited to a $5,000 for air and $1,500 for ground benefit per occurrence. This plan does not include benefits for transportation for non-emergency medical services.
	Urgent care	80% after deductible	60% after deductible up to R&C	
If you have a hospital stay	Facility fee (e.g., hospital room)	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is also a hospital admission copay. A $100 per day copay will apply to all Out-of-Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care.
	Physician/surgeon fees	80% after deductible	60% after deductible up to R&C	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Out-of-Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay

Common Medical Event	Services You May Need	In-Network Benefit	Out-of-Network Benefit	Limitations, Exceptions and Exclusions
	Mental/Behavioral health inpatient services	80% after deductible	60% after deductible up to R&C	does not apply when the admission is related to emergent/immediate care. Inpatient limit fifteen (15) days per calendar year. Outpatient limit to twenty-six (26) visits per calendar year. Expenses for the treatment of a Mental Health condition are paid the same as any other illness. Office Visits are covered the same as any other illness and are covered under the copay.
	Substance use disorder outpatient services	80% after deductible	60% after deductible up to R&C	In addition to the plan's deductible, there is a hospital admission copay. A $100 per day copay will apply to all Out-of-Network hospital admissions. The $100 per day copay will not exceed a maximum of $300 per admission. This copay does not apply when the admission is related to emergent/immediate care. Limit of three (3) Treatment Series per lifetime. Expenses for the treatment of Substance Use Disorder are paid the same as any other illness. Office Visits are covered the same as any other illness and are covered under the copay.
	Substance use disorder inpatient services	80% after deductible	60% after deductible up to R&C	
If you are pregnant	Prenatal and postnatal care	80% after deductible	60% after deductible up to R&C	A copay will apply to the initial office visit charge for in-network services. The remainder of the physician charges will be subject to the deductible and covered at the appropriate benefit percentage.
	Delivery and all inpatient services	80% after deductible	60% after deductible up to R&C	
If you need help recovering or have other special health needs	Home Health Care	80% after deductible	60% after deductible up to R&C	Limited to one hundred (100) visits per calendar year
	Rehabilitation/Habilitation services (Outpatient)	80% after deductible	60% after deductible up to R&C	Outpatient physical therapy, occupational therapy, and aquatic therapy services are limited to a combined calendar year limit of twenty-four (24) visits. Services billed by a chiropractor are limited to ten (10) visits per calendar year for non-surgical treatment only. Chiropractic services never pay at 100% and out-of-pocket expenses do not apply to any out-of-pocket maximums. Outpatient speech services are limited to twelve (12) visits per calendar year. Applied Behavior Analysis Therapy treatment is covered for eligible dependent children under age ten (10) with no maximum benefits per calendar year. Applied Behavior Analysis Therapy treatment for eligible dependent children age ten (10) and older are subject to $36,000 maximum benefits per calendar year.
	Rehabilitation/Habilitation services (Inpatient)	80% after deductible	60% after deductible up to R&C	Limited to thirty (30) days per calendar year.
	Cardiac Rehabilitation (Outpatient)	80% after deductible	60% after deductible up to R&C	
	Skilled nursing care	80% after deductible	60% after deductible up to R&C	Limited to one hundred (100) days per calendar year
	Durable medical equipment	80% after deductible	60% after deductible up to R&C	Refer to the Pre-Authorization Requirements on the SPD or in the Medical Management section of the Medical Book.
	Hospice services	80% after deductible	60% after deductible up to R&C	Does ***not*** include Respite Care or Bereavement Counseling.

Common Medical Event	Services You May Need	In-Network Benefit	Out-of-Network Benefit	Limitations, Exceptions and Exclusions
If your child needs dental or eye care *(attained age of nineteen (19))*	Eye exam			Vision Acuity Screenings-paid as Preventive under Medical Plan-100% allowed Reasonable and Customary (R&C). Vision screening services [for the detection of eye disease and refractive disorders and well-child visits that include visual acuity testing stereoacuity, cover-uncover tests, Hirschberg light reflect test, Hirschberg light reflex test, autorefraction and photoscreening may be done starting age three (3) to attained age of five (5) years] as required by law.
	Glasses	Ineligible under Medical Plan		
	Dental check-up			Dental Screenings-paid as Preventive under Medical Plan-100% allowed Reasonable and Customary (R&C). Pediatric oral [application of fluoride varnish to the primary teeth of all infants starting at the age of primary tooth eruption; recommended at six (6), nine (9), twelve (12), eighteen (18), twenty-four (24), thirty (30) months, three (3) and six (6) years].

General Exclusions or Limitations - No benefits shall be payable under any part of the Plan with respect to any charges. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: tmlhealthbebefits.org •Select: Find a Form •Select: Benefits •Select: Medical •Medical Plan Book

No Benefits shall be payable under any part of this Plan with respect to any charges:

1. For which a Covered Person is not financially responsible or are submitted only because medical coverage exists or for discounts for which the Covered Person is not responsible, including but not limited to independent and preferred provider discounts;
2. For services not performed for the diagnosis or treatment of an illness or injury unless covered as part of the Preventive/Routine Care Benefit;
3. For treatment of any injury or illness for which the Covered Person is not under the regular care of a physician or does not follow the attending physician's treatment plan;
4. For expenses applied under this Plan toward satisfaction of any deductibles, copayments, benefit percentage or access charge;
5. In excess of reasonable and customary for services and supplies;

This is not a complete list. Refer to the Medical Plan Book for a complete list of Exclusions and Limitations: Login: tmlhealthbebefits.org •Select: Find a Form •Select: Benefits •Select: Medical •Medical Plan Book

Extenuating Circumstances

If a Covered Person requires care from a specialist care provider but there is not an in-network specialist care provider within a seventy-five (75) mile radius from the employee's place of business, the provider will be paid at in-network benefits subject to R&C allowable amounts.

Your Rights to Continue Coverage. Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information about your rights and obligations under the plan and under federal law, you should review the plan booklet or contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone at (800) 282-5385. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. For more information about the Marketplace, visit www.healthcare.gov or call (800) 318-2596.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". Yes, this plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). Yes, this plan's coverage meets the minimum value standard.

Your Grievance and Appeals Rights. If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Medical Plan booklet also provides complete information to submit a claim appeal or a grievance for any reason. For assistance, contact TML Health, PO Box 149190, Austin, Texas 78714-9190 or by telephone (800) 282-5385. You may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or www.cciio.cms.gov.

About these Coverage Examples. These examples show how this plan might cover medical care in a few situations and show how deductibles, copayments, and benefit percentage can add up. Use these examples to see, in general, how much financial protection a sample patient might get from coverage under this plan compared to other plans by comparing the "Covered Individual Pays" section for the same example under each plan's Summary of Benefits and Coverage. **This is not a cost estimator.** Do not use these examples to estimate your actual costs under this plan. Treatments show are just examples and your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Also, costs do not include premiums you pay to buy coverage under a plan.

Having a Baby (normal delivery)	
• Amount owed to Providers:	$13,772.46
• Plan pays:	$11,247.46
• Covered Individual/Patient pays:	$2,500.00
Sample Care Costs	
Hospital charges (mother)	$5,829.57
Hospital charges (baby):	$1,505.65
Routine obstetric care:	$3,313.16
Anesthesia:	$2,200.00
Laboratory tests:	$325.96
Prescriptions:	$45.00
Radiology:	$553.12
Total:	**$13,722.46**
Covered Individual/Patient Pays	
Deductible:	$500.00
Copayments: Medical/Rx:	$25.00/$0.00
Coinsurance:	$1,975.00
Plan/Max Plan OOP:	$2,500.00
Limits or Exclusions:	$0.00
Total:	**$2,500.00**

Managing Type 2 Diabetes (routine maintenance of a well-controlled condition)	
• Amount owed to Providers:	$8,673.52
• Plan pays:	$7,441.18
• Covered Individual/Patient pays:	$1,232.34
Sample Care Costs	
Prescriptions:	$7,138.32
Medical Equip. & Supplies:	$208.32
Office Visits and Procedures:	$858.20
Education:	$204.50
Laboratory tests:	$116.54
Vaccines, other preventive:	$147.64
Total:	**$8,673.52**
Covered Individual/Patient Pays	
Deductible:	$170.34
Copayments: Medical/Rx:	$150.00/$912.00
Coinsurance:	$0.00
Plan/Max Plan OOP:	$1,232.34
Limits or Exclusions:	$0.00
Total:	**$1,232.34**

Simple Fracture (with emergency room visit)	
• Amount owed to Providers:	$3,383.56
• Plan pays:	$2,252.62
• Covered Individual/Patient pays:	$1,130.94
Sample Care Costs	
Emergency Services:	$2,319.54
Medical Equip. & Supplies:	$128.10
Office Visits and Procedures:	$598.13
Physical Therapy:	$307.74
Laboratory tests:	$0.00
Prescriptions:	$30.05
Total:	**$3,383.56**
Covered Individual/Patient Pays	
Deductible:	$500.00
Copayments: Medical/Rx:	$75.00/$0.00
Coinsurance:	$455.94
Plan/Max Plan OOP:	$1,030.94
Limits or Exclusions:	$100.00
Total:	**$1,130.94**

Guidance document appears at 77Fed Reg. 8668 and 8706 respectively (2-14-12). Culturally Linguistic documents are available by calling (800) 282-5385 or emailing Customer Care.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other hyperlinked terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (800) 282-5385 to request a copy.

Non-Discrimination

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

- 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, and other 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 our Civil Rights Coordinator. If you believe that TML Health 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, TML Health, PO Box 149190, Austin, TX 78754-9190, (800) 282-5385, TTY 711, Fax (512) 719-6539, CRCoordinator@tmlhb.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call (800) 282-5385.

Spanish ---------------------------- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 282-5385.

Vietnamese ----------------------- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 282-5385.

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 (800) 282-5385.

Korean ---------------------------- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 282-5385 번으로 전화해 주십시오. ◦

Arabic ------------------------------ والبكم الصم هاتف - . برقم اتصل .بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا :ملحوظة -5385-282 (800)) رقم

Urdu --------------------------------- کریں 5385-282 (800) کال . ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ہیں، بولتے اردو آپ اگر :خبردار

Tagalog ---------------------------- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 282-5385.

French ----------------------------- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 282-5385.

Hindi --------------------------------- ध्यान द□: य□द आप □हदी बोलते ह □तो आपके िलए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ (800) 282-5385 पर कॉल कर□।

Persian (Farsi) ------------------- **توجه**: بگیرید تماس با .باشد می فراهم 5385-282 (800) شما برای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فارسی زبان به اگر.

German ---------------------------- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 282-5385.

Gujarati --------------------------- **ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્ક ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો** (800) 282-5385.

Russian ---------------------------- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 282-5385.

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。(800) 282-5385まで、お電話にてご連絡ください。

Laotian ---------------------------- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 282-5385.