



**Blue Shield of California Life & Health  
Insurance Company  
Summary of Benefits**

**Group Vision Plan  
PPO Plan**

**Preferred Vision Plus for Small Business 10/25/150/150**

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).<sup>1</sup> Please read both documents carefully for details.

**Provider Network:**

This Plan uses a contracted network of vision care providers. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at [blueshieldca.com](https://blueshieldca.com).

**Benefit Frequency Limits**

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

|                                           |                                  |
|-------------------------------------------|----------------------------------|
| <b>Comprehensive exam</b>                 | One every 12 consecutive months  |
| <b>Eyeglass lenses and contact lenses</b> | Once every 12 consecutive months |
| <b>Eyeglass frame</b>                     | One every 24 consecutive months  |
| <b>Low vision testing</b>                 | One every 12 consecutive months  |
| <b>Diabetes management referral</b>       | One every Calendar Year          |

**Waiting Period**

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

|                       |                   |
|-----------------------|-------------------|
| <b>Waiting period</b> | No waiting period |
|-----------------------|-------------------|

**No Deductible**

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

**No Lifetime Dollar Limit**

Under this Plan there is no dollar limit on the total amount Blue Shield Life will pay for Covered Services in an Insured's lifetime.

|                                                                                                                                                                                                         | When using a Participating Provider <sup>3</sup> | When using a Non-Participating Provider <sup>4</sup> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------|
| <b>Eye examinations</b>                                                                                                                                                                                 |                                                  |                                                      |
| Comprehensive exam<br><i>One per Insured every 12 months.</i>                                                                                                                                           |                                                  |                                                      |
| Ophthalmologic visit                                                                                                                                                                                    | \$10                                             | All charges above \$60                               |
| Optometric visit                                                                                                                                                                                        | \$10                                             | All charges above \$50                               |
| Retinal Imaging<br><i>One per Insured every 12 months by a Participating Provider instead of a standard comprehensive exam with dilation.</i>                                                           | \$39                                             | Not covered                                          |
| Standard contact lens fitting and evaluation<br><i>One per Insured every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.</i>                          | \$10                                             | Not covered                                          |
| <b>Eyewear/Materials</b>                                                                                                                                                                                |                                                  |                                                      |
| Eyeglass frame<br><i>One per Insured every 24 months.</i>                                                                                                                                               | \$25 plus all charges above \$150                | All charges above \$40                               |
| Plano (non-prescription) sunglasses<br><i>One per Insured every 24 months instead of an eyeglass frame when prescribed by a Participating Provider or surgeon after vision correction surgery.</i>      | \$25 plus all charges above \$150                | Not covered                                          |
| Eyeglass lenses and lens treatments<br><i>One pair of lenses per Insured every 12 months. Each pair of eyeglass lenses includes pink or rose tint #1 or #2 in the Allowance and up to 61mm in size.</i> |                                                  |                                                      |
| • Single vision                                                                                                                                                                                         | \$25                                             | All charges above \$43                               |
| • Lined bifocal                                                                                                                                                                                         | \$25                                             | All charges above \$60                               |
| • Lined trifocal                                                                                                                                                                                        | \$25                                             | All charges above \$75                               |
| • 7.25 diopter, or more                                                                                                                                                                                 | \$25                                             | All charges above \$12                               |
| • Aphakic monofocal                                                                                                                                                                                     | \$25                                             | All charges above \$120                              |
| • Aphakic multifocal                                                                                                                                                                                    | \$25                                             | All charges above \$200                              |
| • Lenticular monofocal                                                                                                                                                                                  | \$25                                             | All charges above \$120                              |
| • Lenticular multifocal                                                                                                                                                                                 | \$25                                             | All charges above \$200                              |
| • Prism 1 1/2 to 4 diopters                                                                                                                                                                             | \$25                                             | All charges above \$10                               |
| • Prism 4 1/2 to 10 diopters                                                                                                                                                                            | \$25                                             | All charges above \$16                               |
| • Slab-off prism (per lens)                                                                                                                                                                             | \$25                                             | All charges above \$35                               |
| • Polycarbonate lenses (for Dependent children only)                                                                                                                                                    | \$25 plus all charges above \$100                | All charges above \$75                               |

|                                                                                                                                                                                                                                                                                                                                                  | When using a Participating Provider <sup>3</sup> | When using a Non-Participating Provider <sup>4</sup> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Polycarbonate photochromic single vision lenses (for Dependent children only)</li> </ul>                                                                                                                                                                                                                  | \$25 plus all charges above \$160                | All charges above \$115                              |
| <ul style="list-style-type: none"> <li>Standard progressive lenses (no-line bifocals)</li> </ul>                                                                                                                                                                                                                                                 | Not covered                                      | Not covered                                          |
| <ul style="list-style-type: none"> <li>Premium progressive lenses (no-line bifocals)</li> </ul>                                                                                                                                                                                                                                                  | \$25 plus all charges above \$140                | All charges above \$100                              |
| <ul style="list-style-type: none"> <li>Anti-reflective lens coating</li> </ul>                                                                                                                                                                                                                                                                   | \$25 plus all charges above \$50                 | All charges above \$35                               |
| <ul style="list-style-type: none"> <li>Photochromic lenses</li> </ul>                                                                                                                                                                                                                                                                            |                                                  |                                                      |
| Single vision                                                                                                                                                                                                                                                                                                                                    | \$25 plus all charges above \$115                | All charges above \$85                               |
| Lined bifocal                                                                                                                                                                                                                                                                                                                                    | \$25 plus all charges above \$130                | All charges above \$95                               |
| Lined trifocal                                                                                                                                                                                                                                                                                                                                   | \$25 plus all charges above \$150                | All charges above \$110                              |
| Premium progressive (no-line bifocals)                                                                                                                                                                                                                                                                                                           | \$25 plus all charges above \$200                | All charges above \$150                              |
| <p>Contact lenses</p> <p><i>Elective or Non-Elective Contact Lenses are provided per Insured every 12 months. Benefits are provided in addition to eyeglass frames and lenses by a Participating Provider up to the Allowance. When using a Non-Participating Provider, the Allowance is provided instead of eyeglass frames and lenses.</i></p> |                                                  |                                                      |
| <ul style="list-style-type: none"> <li>Elective (cosmetic/convenience) - hard or soft</li> </ul>                                                                                                                                                                                                                                                 | \$25 plus all charges above \$150                | All charges above \$150                              |
| <ul style="list-style-type: none"> <li>Non-Elective (Medically Necessary) - hard</li> </ul> <p><i>Requires a report from the provider and prior authorization from the VPA.</i></p>                                                                                                                                                              |                                                  |                                                      |
| Aphakia                                                                                                                                                                                                                                                                                                                                          | \$25 plus all charges above \$250                | All charges above \$200                              |
| Anisometropia                                                                                                                                                                                                                                                                                                                                    | \$25 plus all charges above \$300                | All charges above \$200                              |
| Astigmatism                                                                                                                                                                                                                                                                                                                                      | \$25 plus all charges above \$300                | All charges above \$200                              |
| Hyopia                                                                                                                                                                                                                                                                                                                                           | \$25 plus all charges above \$250                | All charges above \$200                              |
| Keratoconus                                                                                                                                                                                                                                                                                                                                      | \$25 plus all charges above \$350                | All charges above \$200                              |
| Myopia                                                                                                                                                                                                                                                                                                                                           | \$25 plus all charges above \$250                | All charges above \$200                              |
| <ul style="list-style-type: none"> <li>Non-Elective (Medically Necessary) - soft</li> </ul> <p><i>Requires a report from the provider and prior authorization from the VPA.</i></p>                                                                                                                                                              |                                                  |                                                      |

## Benefits<sup>2</sup>

## Your payment

|                                                                                                                                                                                                                         | When using a Participating Provider <sup>3</sup> | When using a Non-Participating Provider <sup>4</sup> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------|
| Aphakia                                                                                                                                                                                                                 | \$25 plus all charges above \$250                | All charges above \$250                              |
| Anisometropia                                                                                                                                                                                                           | \$25 plus all charges above \$300                | All charges above \$250                              |
| Astigmatism                                                                                                                                                                                                             | \$25 plus all charges above \$300                | All charges above \$250                              |
| Hyopia                                                                                                                                                                                                                  | \$25 plus all charges above \$250                | All charges above \$250                              |
| Keratoconus                                                                                                                                                                                                             | \$25 plus all charges above \$350                | All charges above \$250                              |
| Myopia                                                                                                                                                                                                                  | \$25 plus all charges above \$250                | All charges above \$250                              |
| <b>Other services</b>                                                                                                                                                                                                   |                                                  |                                                      |
| Low-vision testing and equipment<br><br><i>One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.</i> | 25% plus all charges above \$1,000               | Not covered                                          |
| Diabetes management referral<br><br><i>One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.</i>                                                        | \$0                                              | Not covered                                          |

## Notes

### 1 Certificate of Insurance (COI):

The Certificate of Insurance (COI) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the COI for more details of coverage outlined in this Summary of Benefits. You can request a copy of the COI at any time.

Capitalized terms are defined in the COI. Refer to the COI for an explanation of the terms used in this Summary of Benefits.

### 2 Vision Care Services:

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

Contact lenses. The allowance for contact lenses may not be combined with the frame Allowance nor be used towards the fitting fees. If you receive Elective or Non-Elective Contact Lenses from a Non-Participating Provider, no Benefits will be available for eyeglass frames and lenses until you satisfy the Benefit frequency.

### 3 Using Participating Providers:

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

When the Participating Provider uses wholesale or warehouse pricing, the maximum frame Allowances are:

- wholesale Allowance: \$99.06.
- warehouse Allowance: \$103.64.

**Note:** This pricing replaces the frame Allowance shown in the Summary of Benefits. If a more expensive frame is selected at a provider location that uses wholesale or warehouse pricing, the Insured Person is responsible for the additional cost above the wholesale or warehouse Allowance. Participating Providers using wholesale or warehouse pricing are identified in the directory of Participating Providers at [blueshieldca.com](https://blueshieldca.com).

Participating Providers maintain a selection of frames that retail within the Allowance of this plan with lenses that fit an eye size less than 61 millimeters.

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### 4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide vision care services to Insureds. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment, and
  - any charges above the stated Allowance, which is the Benefit maximum.
- 

Plans may be modified to ensure compliance with State and Federal requirements.

# Blue Shield of California Life & Health Insurance Company

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

Blue Shield of California Life & Health Insurance Company complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California Life & Health Insurance Company does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield Life:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield Life Civil Rights Coordinator.

If you believe that Blue Shield Life has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

**Blue Shield of California Life & Health Insurance  
Company Civil Rights Coordinator**  
P.O. Box 629007  
El Dorado Hills, CA 95762-9007  
  
**Phone: (844) 831-4133 (TTY: 711)**  
**Fax: (844) 696-6070**  
**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)**

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 may also contact the California Department of Insurance if you believe that Blue Shield of California Life & Health Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. You can file a grievance with:

California Department of Insurance  
Consumer Communications Bureau  
300 S. Spring Street, South Tower  
Los Angeles, CA 90013

Phone: 1-800-927-HELP (4357) or TDD 1-800-482-4833

Complaint forms are available at

**[www.insurance.ca.gov/01-consumers/101-help](http://www.insurance.ca.gov/01-consumers/101-help)**

If you believe that you have not been provided these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at

**[www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html)**.

# Notice of the Availability of Language Assistance Services

## Blue Shield of California Life & Health Insurance Company

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվական Ծառայություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ գանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով գանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

**خدمات مجانی مربوط به زبان.** می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਬਾਈ ਦੇ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាភាគតិចថ្លៃ៖** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمة بدون تكلفة.** يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

**Doo bááh ílínígó saad bee yát'i' bee aná'áwo'.** Díí shá ata'halne'dooígí hólóqodoo nínízingo éí bííghah. Naaltsoos naanináhájeehígí shich'í' yíidooltah éí doodagó ła' shich'í' ádoolníł nínízingo bííghah. Shíká a'doowoł nínízingo nihich'í' béesh bee hodíílnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'díłzinígí bine'dée' bikáá' éí doodagó éí (866)346-7198jí' hodíílnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'áah naa'nil bíł haz'áají' 1-800-927-4357jí' hodíílnih. Navajo

**ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ.** ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian