



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, [www.healthplanofnevada.com](http://www.healthplanofnevada.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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-777-1840 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Not Applicable	Not Applicable
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$6,250 / Member and \$12,500 / Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Penalties for not obtaining any required <u>prior authorization</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.healthplanofnevada.com/Member/Doctor-or-Provider">www.healthplanofnevada.com/Member/Doctor-or-Provider</a> or call 1-800-777-1840 for a list of <u>Plan Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

\*For more information about limitations and exceptions, see the plan or policy document at [www.healthplanofnevada.com](http://www.healthplanofnevada.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit	Not Covered	None
	<u>Specialist</u> visit	\$70 <u>copay</u> /visit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Preventive care/ screening/ immunization</u>	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$25 <u>copay</u> /service Lab: \$15 <u>copay</u> /service	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Imaging (CT/PET scans, MRIs)	MRI: \$100 <u>copay</u> /service PET Scan: \$100 <u>copay</u> /service CT: \$100 <u>copay</u> /service	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.healthplanofnevada.com">www.healthplanofnevada.com</a>	Tier 1	\$25 <u>copay</u> /prescription (retail) \$62.50 <u>copay</u> /prescription (mail)	Not Covered	You have a 3-Tier pharmacy <u>plan</u> . Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if <u>prior authorization</u> or step therapy is not obtained.
	Tier 2	\$50 <u>copay</u> /prescription (retail) \$125 <u>copay</u> /prescription (mail)	Not Covered	
	Tier 3	\$75 <u>copay</u> /prescription (retail) \$187.50 <u>copay</u> /prescription (mail)	Not Covered	
	Tier 4	Not Applicable	Not Applicable	

\*For more information about limitations and exceptions, see the plan or policy document at [www.healthplanofnevada.com](http://www.healthplanofnevada.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: \$400 <u>copay/surgery</u> Ambulatory Surg Center: \$250 <u>copay/surgery</u>	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	Hospital: \$250 <u>copay/surgery</u> Ambulatory Surg Center: \$125 <u>copay/surgery</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	ER Facility: \$400 <u>copay/visit</u> ER Physician: No charge	ER Facility: \$400 <u>copay/visit</u> ER Physician: No charge	You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .
	<u>Emergency medical transportation</u>	\$400 <u>copay/trip</u>	\$400 <u>copay/trip</u>	
	<u>Urgent care</u>	\$40 <u>copay/visit</u>	\$40 <u>copay/visit</u>	You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay/day</u> \$1500 max/admit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	\$250 <u>copay/surgery</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay/visit</u>	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Inpatient services	\$500 <u>copay/day</u> \$1500 max/admit	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Routine prenatal care obtained from a <u>Plan Provider</u> is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	Surgical: \$250 <u>copay/admit</u> Anesthesia: \$200 <u>copay/admit</u>	Not Covered	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Childbirth/delivery facility services	\$500 <u>copay/day</u> \$1500 max/admit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.

\*For more information about limitations and exceptions, see the plan or policy document at [www.healthplanofnevada.com](http://www.healthplanofnevada.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$35 <u>copay</u> /visit	Not Covered	Does not include <u>Specialty Prescription Drugs</u> . Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	Not Covered	Coverage is limited to a combined Inpatient and Outpatient benefit of 120 days/visits per year. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit	Not Covered	Coverage is limited to a combined Inpatient and Outpatient benefit of 120 days/visits per year. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Skilled nursing care</u>	\$500 <u>copay</u> /admit	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Durable medical equipment</u>	No charge	Not Covered	For purchase or rental at HPN's option. Purchases are limited to a single type of <u>DME</u> , including repair and replacement, every 3 years. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Hospice services</u>	\$500 <u>copay</u> /admit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Your <u>plan</u> may include certain vision and/or dental services. Please refer to your <u>plan</u> documents for more information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery - One (1) per Lifetime</li> <li>• Chiropractic care - 20 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids - One (1) every three (3) years (including repair/replace)</li> <li>• Limited infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

\*For more information about limitations and exceptions, see the plan or policy document at [www.healthplanofnevada.com](http://www.healthplanofnevada.com)

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.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 [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Nevada Department of Insurance at 888-872-3234 or [www.doi.nv.gov](http://www.doi.nv.gov) or call 1-800-777-1840

## 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 Minimum Value Standards?

**Yes.** If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Tagalog (Tagalog): Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

Chinese (中文): 若需要中文协助, 请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsos bikaa doo.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a baby**  
(9 months of in-network pre-natal care and a hospital delivery)

■ <b>The plan's overall deductible</b>	\$0.00
■ <b>Specialist copayment</b>	\$70.00
■ <b>Hospital (facility) copayment</b>	\$500.00
■ <b>Other copayment</b>	\$200.00

**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	\$12,700.00
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0.00
<u>Copayments</u>	\$1,700.00
<u>Coinsurance</u>	\$0.00
What isn't covered	
Limits or exclusions	\$80.00
<b>The total Peg would pay is</b>	<b>\$1,780.00</b>

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

■ <b>The plan's overall deductible</b>	\$0.00
■ <b>Specialist copayment</b>	\$70.00
■ <b>Hospital (facility) copayment</b>	\$400.00
■ <b>Other copayment</b>	\$15.00

**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	\$5,600.00
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0.00
<u>Copayments</u>	\$1,300.00
<u>Coinsurance</u>	\$0.00
What isn't covered	
Limits or exclusions	\$40.00
<b>The total Joe would pay is</b>	<b>\$1,340.00</b>

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

■ <b>The plan's overall deductible</b>	\$0.00
■ <b>Specialist copayment</b>	\$70.00
■ <b>Hospital (facility) copayment</b>	\$400.00
■ <b>Other copayment</b>	\$25.00

**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	\$2,800.00
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0.00
<u>Copayments</u>	\$1,200.00
<u>Coinsurance</u>	\$0.00
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$1,200.00</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

Health Plan of Nevada and Sierra Health and Life comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card or plan documents.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex; you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

[UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

If you need help filing a complaint, call the toll-free number on your member ID card or plan documents.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Phone: 1-800-368-1019 or 800-537-7697 (TDD)

Mail: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F HHH Building  
Washington D.C. 20201

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>

This notice is available at:

<https://healthplanofnevada.com/content/dam/hpnv-public-sites/documents/NVStandard15Taqlines.pdf>

<https://sierrahhealthandlife.com/content/dam/hpnv-public-sites/documents/NVStandard15Taqlines.pdf>

**ATTENTION:** If you speak **English**, language help and communications in other formats, like large print, are available and free to you. Call the phone number included in this document.

**ATENCIÓN:** Si habla **español (Spanish)**, tiene acceso gratuito a asistencia lingüística y a materiales en otros formatos, como impresión en tamaño grande. Llame al número de teléfono que aparece en este documento.

**ATENSYON:** Kung nagsasalita ka ng **Tagalog**, ang tulong sa wika at komunikasyon sa iba pang mga format, tulad ng malalaking print, ay available at libre para sa iyo. Tawagan ang numero ng teleponong kasama sa dokumentong ito.

تنبيه: إذا كنت تتحدث اللغة العربية المساعدة واللغة والنوازل بتسويات أخرى، مثل الطباعة بحروف كبيرة، متاحة لك مجانًا. يرجى الاتصال برقم الهاتف المذكور في هذا المستند.

**মনোযোগ দিন:** আপনি যদি **বাংলায় (Bengali)**, কথা বলেন, তাহলে ভাষা সহায়তা এবং বড় প্রিন্টের মতো অন্যান্য ফর্ম্যাটে যোগাযোগ আপনার জন্য বিনামূল্যে উপলভ্য। এই নথিতে দেওয়া ফোন নম্বরের কল করুন।

**ARONGGORONG:** Ngare' ukassal falawasch, eyoor ailillis me' **arongorong (Carolinian)**, llon akaaw met, gnare' min tuttumogh na iisch, emween ubwe ya'ya' sin ubwe abwos. Faingii numero ye eno won documento yen.

**ATENSION:** Yanggen fumimino' **Chamorro** hao, guaha dibåtde para hagu na ayudun lengguahi yan kumunikasion ni diferentes na fotmat, yan danglulo na tinigi'. Agang i numero nai gaige guini na dokumento.

**注意:** 如果您說**中文(Chinese)**，您可以免費獲得語言協助和其他格式（例如大字版）的通訊。請撥打本文件內的電話號碼。

توجه: اگر یہ فارسی (Farsi) صحبت میکنید، خدمات کمکی زبان و مطالب در قالبهای دیگر، مانند پرینت درشت، بصورت رایگان برای شما فراهم است. با شماره تلفنی که در این سند ذکر شده، تماس بگیرید.

**ATTENTION:** si vous parlez **français (French)**, une assistance linguistique et des communications dans d'autres formats, tels que du texte en gros caractères, sont gratuitement mis à votre disposition. Appelez le numéro de téléphone inclus dans ce document.

**HINWEIS:** Wenn Sie **Deutsch (German)**, sprechen, stehen Ihnen Sprachdienste und Mitteilungen in anderen Formaten, wie z. B. in Großdruck, kostenlos zur Verfügung. Rufen Sie die in dieser Mitteilung angegebene Telefonnummer an.

**ધ્યાન આપી:** જો તમે ગુજરાતી (Gujarati), બોલો છો, તો ભાષા સહાય અને સંદેશાલેખકાર અન્ય ફોર્મેટમાં, જેમ કે મોટી પ્રિન્ટમાં, તમારા માટે નિ:શુલ્ક અને ઉપલબ્ધ છે. આ દસ્તાવેજમાં આપેલા ફોન નંબર પર કોલ કરો.

**ATANSYON:** Si w pale **Kreyòl Ayisyen (Haitian Creole)**, genyen èd pou lang ou a disponib gratis pou ou ansann ak komunikasyon nan lòt fòm, pa egzanp gwo lèt. Rele nan nimewo telefòn ki nan dokiman sa a.

**ध्यान दें:** यदि आप **हिन्दी (Hindi)**, बोलते हैं, तो भाषा संबंधी मदद और अन्य प्रारूपों, जैसे बड़े प्रिंट, में संचार, आपके लिए उपलब्ध और निःशुल्क है। इस दस्तावेज़ में शामिल किए गए फ़ोन नंबर पर कॉल करें।

**ATTENZIONE:** se parla **italiano (Italian)**, può usufruire gratuitamente di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero di telefono riportato in questo documento.

**注意:** 日本語(**Japanese**),を話される場合は、言語サポートや大きな活字などの他の形式でのコミュニケーションを無料でご利用いただけます。本書に記載されている電話番号までお電話ください。

**참고:** 한국어를 (**Korean**) 구사하신다면 언어 지원 및 의사소통을 큰 인쇄물과 같은 형식으로도 무료로 이용하실 수 있습니다. 본 문서에 있는 전화번호로 전화하십시오.

**BAĀ' ĀKONĪNĪZĪN:** **Diné (Navajo)**, bizaad bee yániłt'igo, saad bee áka'aná'awo' dóó bee ahít dahane'i náána'ahgo át'éego bee hada'dilyaigií, díi nitsaa bee ak'eda'ashchini t'áá jiik'eh ná dahóó. Díi naaltsos bee éédahóziní bąąh námboo biká'igií bee hodilinih.

**WĪCHDĪCH:** Wann du **Deutsch (Pennsylvania Dutch)**, schwetscht, kenne mer dich Schprooch-Hilf griege, wann du's brauchsch, un Information in differnti Wege, so wie gross Schreiwes (large print). All sell zellt dich nix koschde. Call der Toll-Free-Number as do debei is.

**UWAGA:** jeśli mówisz po **polsku (Polish)**, oferujemy bezpłatną pomoc językową i materiały w innych formatach, w tym napisane dużym drukiem. Zadzwoń pod numer telefonu wskazany w tym dokumencie.

**ATENÇÃO:** se você fala **português (Portuguese)**, a ajuda com o idioma e as comunicações em outros formatos, como letras grandes, por exemplo, estão disponíveis e são gratuitas. Ligue para o número de telefone incluído neste documento.

**ВНИМАНИЕ:** Если Вы говорите по-**русски (Russian)**, Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Позвоните по номеру телефона, указанному в этом документе.

**MO LE SILA'FIĀ:** Pe afai e te tautala i le faa-**Samoa (Samoa)**, o le fesoasoani tau gaugana ma feso'ota'iga i isi auāla, e pei o lomiga e laloro'a mata'itusi, o loo avanoa mo oe auāoa ma se totogi. Valaau le numera o le telefoni o loo aofia ai i lenei pepa.

توجّه فرمائیں: اگر آپ اردو (**Urdu**) بولتے ہیں تو بڑے پرنٹ جیسی دوسری شکلوں میں اساتقی امداد اور مواصلات آپ کے لیے مفت میں دستیاب ہوتی ہیں۔ اس دستاویز میں شامل فون نمبر پر کال کریں۔

**LƯU Ý:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được hỗ trợ ngôn ngữ miễn phí và các định dạng thông tin miễn phí khác như bản in khổ lớn. Hãy gọi số điện thoại có trong tài liệu này.