The Local Choice Health Benefits

Dental/Vision Benefits Insert

January 2025

This insert, along with The Local Choice Medicare-Coordinating Plans Member Handbook, constitutes a complete description of the benefits, exclusions and limitations under the plan for enrollees who are eligible for and have elected these benefits.

Important Notice 1
Using Your Dental/Vision Benefits to Your Best Advantage 2
Summary of Benefits 3
Who to Contact for Assistance 4
General Rules Governing Benefits 6
Dental Benefits 7
Vision Benefits 12
Exclusions 16
Basic Plan Provisions 16
Definitions 16
Eligibility 16
Commonwealth of Virginia's Health Benefits Programs Nondiscrimination Notice 17
Get Help in Your Language 18

The Local Choice Health Benefits Program
Administered by the Department of Human Resource Management
Commonwealth of Virginia

A10789 (11/2024)

IMPORTANT NOTICE

This insert describes the dental and vision services that are available for reimbursement under The Local Choice Health Benefits Program if you are enrolled in a Plan that includes these benefits. The plans that include these benefits are Advantage 65 with Dental/Vision and Medicare Complementary.

Throughout this insert there are words which begin with capital letters. In most cases, these are defined terms. See the "Definitions" sections of your Medicare-Coordinating Plans Member Handbook and this insert for the meaning of these words.

Your Dental/Vision coverage is limited to the services specifically described in this insert as eligible for reimbursement. There are specific Exclusions for which the program will never pay. Even more important, payment for covered services is almost always conditional. That is, payment may be denied for covered services you receive without observing all of the conditions and limits under which they are covered.

Your benefits are governed strictly by the written provisions of this coverage. Only those dental and vision services specifically named or described in this insert are covered. You are responsible for knowing what is covered and the limits and conditions of coverage. The terms and conditions of your coverage can be changed if proper notice is given to you.

There are some rules and information that apply to all benefits (medical and dental/vision based on your own coverage), including applicable "General Rules Governing Benefits", "Exclusions", "Basic Plan Provisions", "Definitions" and "Eligibility" that are included in your Local Choice Health Benefits Program Medicare-Coordinating Plans Member Handbook. In addition, any rules or information that applies specially to Dental/Vision benefits will be included in this insert.

USING YOUR DENTAL/VISION BENEFITS TO THE BEST ADVANTAGE

Use of Participating Providers in the claims administrators' networks will ensure that you are not charged above the network Allowable Charge level. If you use a Non-Participating Provider, you will have to pay any charges over the Allowable Charge level or a higher co-payment or coinsurance as described in this insert, and you may have to file your own claim.

Since Medicare does not cover routine dental and vision services, the Dental/Vision coverage under your Plan does not coordinate with Medicare. However, when it is requested, you must report any other coverage in which you are enrolled so that your benefits may be coordinated as described in the "Coordination of Benefits" section of "General Rules Governing Benefits" in your Medicare-Coordinating Plans Member Handbook.

SUMMARY OF BENEFITS

	Covered Services	you Pay
Dental	Plan pays up to $1,500 per participant per Calendar Year: • Diagnostic and Preventive Care • Basic Dental Care • Major Dental Care	 $0 of AC* 20% of AC* 95% of AC*
Vision	Plan pays for the following routine vision benefits once per calendar year	
(in-network provider)**	Routine eye exam (one)	$20 copayment
	Eyeglass frames (one pair)	Charges over $100 allowance (20% off remaining balance)
	Eyeglass Lenses	
	• Standard plastic single vision lenses (one pair)	$20 copayment
	• Standard plastic bifocal lenses (one pair)	$20 copayment
	• Standard plastic trifocal lenses (one pair)	$20 copayment
	• Standard progressive lenses (one pair)	$85 copayment
	Contact lenses	
	• Elective conventional lenses	Charges over the $100 allowance (15% off remaining balance)
	• Elective disposable lenses	Charges over the $100 allowance (no additional discount)
	• Non-elective contact lenses	Covered in Full

* Allowable Charge

** Out-of-Network vision benefits are outlined in the Blue View Vision section of this insert.

WHO TO CONTACT FOR ASSISTANCE

Dental Plan Claims Administration

Anthem Blue Cross Blue Shield

Customer Service	855-648-1411
Web Address	**www.anthem.com/tlc**
Hours of Operation	Monday through Thursday, 8:00 a.m. to 9:00 p.m.
Mailing Address	PO Box 1115 Minneapolis, MN 55440-1115

Vision Plan Claims Administration

Anthem Blue Cross and Blue Shield – Blue View Vision

Member Services	800-552-2682
Web Address	**www.anthem.com/tlc**
Mailing Address	Anthem Blue Cross and Blue Shield Member Services P. O. Box 27401 Richmond, VA 23279
Hours of Operation	Monday through Friday, 8:00 a.m. to 6:00 p.m.
ID Card Order Line	866-587-6713

Eligibility and Enrollment

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
(804) 786-6460
www.thelocalchoice.virginia.gov

Program Administration

Department of Human Resource Management
The Local Choice Health Benefits Program

Web address	**www.thelocalchoice.virginia.gov**
E-mail	**tlc@dhrm.virginia.gov**

GENERAL RULES GOVERNING BENEFITS

All applicable “General Rules Governing Benefits” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert.

DENTAL BENEFITS

Services Which Are Eligible for Reimbursement

Diagnostic and Preventive Care

This plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and try to prevent cavities and seriousdental problems. The following services are generally covered, but in some specific situations, certain exclusions and limitations apply. See “Special Limits” in this section, the“Exclusions” section of this booklet, and your Medicare-Coordinating Plans Member Handbook for more information.

- Two routine oral evaluations per Plan Year;
- Two dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Space maintainers used to keep teeth from moving into space left when deciduous teethare pulled; (available to Covered Persons under age 16;)
- Care for a toothache (palliative emergency care), limit of 2 every 12 months;
- Bitewing x-rays (two or more films) once per Calendar Year;
- One complete full-mouth x-ray series (or a panorex every 5 years (the 5 year count starts the month in which you receive the x-ray series or panorex);
- Two topical fluoride applications per Calendar Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are limited to once per lifetime and available only to Covered Persons under age 19;
- Occlusal adjustments (limit of 2 every 12 months), and bite planes or splints for temporomandibular joint disorders.
- Occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once in 36 months;

Basic Dental Care

Covered services include:

- Fillings (amalgam or composite resin), limit of one every 24 months;
- Pin retention (once every 24 months);
- Simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- Root canal therapy (endodontics), once per lifetime;
- Care for abscesses in the mouth (excision and drainage);
- Repair of broken removable dentures (once every 12 months);
- Surgical preparation of ridges for dentures (once every 60 months);
- Re-cementing existing crowns, inlays and bridges (one every 12 months);

- Removing infected parts of the gum (gingivectomy and gingivoplasty), once every 36 months;
- Scaling and root planning of the gum—two year limitation);
- Stainless steel crowns for primary teeth only (one every 24 months);
- Sedative fillings (one every 3 months);
- Therapeutic pulpotomy (once per lifetime);
- An operation to remove diseased portions of bone around the teeth (osseous surgery), one every 36 months;
- Soft tissue grafts to replace lost or unhealthy gum tissue (one per 36 months);
- Bone graft (only around natural teeth);
- Guided tissue regeneration;
- General anesthesia or IV sedation is covered when performed in connection with a covered, complex surgical dental service;
- Crown lengthening when bone is removed and at least six weeks are allowed for healing;
- Hemisection and root amputations;
- Apicoectomies (3 every 36 months);
- Surgical periodontic services (soft tissue and bony surgery, including grafts)—three year limitation;
- Full mouth debridement (once per lifetime);
- Core build ups (once per tooth every 5 years);
- Restorative (amalgam or composite resin and other restorative services) retreatment limited to once per surface in a 2 year period;
- Periodontal maintenance (limited to two (2) per Calendar Year); and
- Trips by the dentist to your home if you need any of the services you see listed here.

Major Dental Care

Covered services include:

- Inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- Onlays (limited to the benefit for a metallic restoration);
- Crowns, crown repair, and post and core build-ups for crowns (once per tooth every 7 years);
- Labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once every 7 years);
- Dentures (full or partial) once every 7 years, and denture adjustments and relining;
- Fixed bridges once every 7 years, and repair.

Note: Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every 7-year period. There is one exception; replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

Enhanced Benefits for Select Participants

Research has determined a direct connection between your dental health and the impact on your overall health, especially when dealing with a medical condition. With the Anthem Whole Health Connection® program, participants who have been diagnosed with the following will receive an additional in-network exam and dental cleaning or periodontal treatment each calendar year:

- Diabetes;
- Pregnancy (eligible for a maximum of two coverage years);
- Certain cardiac conditions;
- Cancer with chemotherapy treatment;
- Head and neck cancer with chemotherapy and/or radiation treatment;
- Organ or bone marrow transplant candidates;
- End-Stage Renal Disease (ESRD);
- Stroke;
- Suppressed/weakened immune systems (HIV/AIDS).

For more information, visit **www.anthem.com/tlc** or call Anthem Customer Service.

Conditions for Reimbursement

Should you decide to receive dental care from a dentist who is not a Participating Provider, you will still receive benefits from your dental plan, but your share of the cost will likely be higher than if you received care from a Participating Provider. In addition:

- you may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Anthem Blue Cross Blue Shield.
- you must pay the applicable Coinsurance and the difference between the non-Participating Provider that are above Anthem's payment for covered benefits.

Special Limits

1) Benefits are limited to $1,500 per participant per Calendar Year for all services. If you transfer to another Medicare-coordinating plan that includes these benefits, your total annual benefit will still be limited to $1,500.

2) If you transfer from the care of one dentist to another during a course of treatment, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

3) If more than one dentist renders services for one procedure, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

NOTE: If dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Anthem before services are provided. By submitting a predetermination plan, you and your dentist will be informed of: the total costs associated with the procedure(s); the exact amounts that will be covered by your health Plan; and the portion of the charges for which you will be responsible. A predetermination plan is not required by your health Plan, but it is recommended when extensive dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Dental Plan Exclusions

The following services and/or supplies are excluded from coverage:

- Dental supplies;
- Brush biopsies of the oral cavity;
- Services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- Gold foil restorations;
- Athletic mouth guards;
- Temporary dentures, crowns or duplicate dentures;
- Oral or inhalation sedation;
- Bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- Root canal therapy on other than permanent teeth;
- Pulp capping (direct or indirect);
- Upgrading of working dental appliances;
- Precision attachments for dental appliances;
- Tissue conditioning;
- Separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- Separate charges for routine irrigation or re-evaluation following periodontal therapy;
- Analgesics (nitrous oxide);
- General anesthesia and IV sedation except in conjunction with oral surgery, surgical periodontia, or surgicalendodontia and then only when the underlying dental service is a covered benefit;
- Diagnostic photographs;
- Periodontal splinting and occlusal adjustments for periodontal purposes;
- Occlusal analysis;
- Controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- Tooth desensitizing treatments;
- Care by more than one dentist when you transfer from one dentist to another during the course of treatment;

- Care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- Preventive control programs, or oral hygiene instructions;
- Complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under your health Plan or any similar coverage;
- Dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- Services that Anthem determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- Services that Anthem determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- Dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for aesthetic purposes;
- Services billed under multiple dental service procedure codes which Anthem, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Anthem's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes;
- Services covered under medical benefits;
- Any services not listed as covered under Dental Services in this insert;
- Services determined by Anthem, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Anthem will take into account generally accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge after your Coinsurance for covered dental services.

Coinsurance (the amount you pay)

Diagnostic and Preventive Care	0% of Allowable Charge
Basic Dental Care	20% of Allowable Charge
Major Dental Care	95% of Allowable Charge

VISION BENEFITS

Services Which Are Eligible for Reimbursement

1) Routine vision examination, once per Calendar Year

2) Frames and the following prescription lenses to correct refraction error, once per Calendar Year:

- Standard plastic single vision lenses, or
- Standard plastic bifocal lenses, or
- Standard plastic trifocal lenses, or
- Standard progressive lenses, or
- Conventional contact lenses

Conditions for Reimbursement

Vision services must be:

- Billed by a Provider in private practice.
- Rendered by a Provider licensed to do so.
- Received from a Blue View Vision network Provider in order to receive in-network benefits.
- Services received out-of-network will be reimbursed according to the out-of-network allowance.

Special Limits

1) These benefits are available once per Calendar Year.

2) Benefits will not be provided for more than the following in a Calendar Year period:

- One routine vision examination, and
- One pair of frames, and
- One pair of non-contact lenses or the designated allowance toward the cost of a supplyof contact lenses.

Vision Plan Exclusions

Your coverage does not include benefits for the following routine vision services. This list includes the majority of vision services not covered under your Plan, and is not a comprehensive list of all non-covered services.

1) Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism, or contact lenses and eyeglasses required as a result of this surgery.
2) Benefits cannot be combined with any offer, coupon, or in-store advertisement.
3) Prescription sunglasses of any type; however, discounts are available for nonprescription sunglasses, tints or transition lenses.
4) Discounts are not available for certain brand-name frames in which the manufacturer imposes a no-discount policy.
5) Services required by your employer in connection with employment or benefits that would be covered under worker's compensation.
6) Safety glasses and accompanying frames.
7) Hospital Care - Inpatient or Outpatient hospital vision care.
8) Orthoptics or vision training and any associated supplemental testing.
9) Any non-prescription lenses, eyeglasses, contacts, Plano lenses or lenses that have no refractive power.
10) Any other vision services not specifically listed as covered in accordance with the member handbook insert.

Benefit/Reimbursement

Covered Service – In-Network:	**Your cost:**
Routine vision examination	$20 Copayment
Eyeglass frames	**Plan pays** $100 allowance; you pay the remaining balance with a 20% discount
Eyeglass lenses *(one of the following)*	
• Standard plastic single vision lenses (1 pair)	$20 Copayment
• Standard plastic bifocal lenses (1 pair)	$20 Copayment
• Standard plastic trifocal lenses (1 pair)	$20 Copayment
• Standard progressive lenses (1 pair)	$85 Copayment
Retinal Imaging	
At member's option can be performed at time of eye exam (not available out-of-network)	Not more than $39

Eyeglass lens upgrades In addition to the standard eyeglass lens Copayment, you may choose to add one or more of the upgrades below for the additional Copayment(s).

• UV coating	$15 copayment
• Tint (solid and gradient)	$15 copayment
• Standard scratch-resistance	$15 copayment
• Standard polycarbonate	$40 copayment
• Standard anti-reflective coating	$45 copayment
• Other add-ons and services	you pay the cost with a 20% discount

Contact lenses
You may choose to receive contact lenses instead of eyeglasses (frames and lenses).

• Elective Conventional lenses	**Plan pays** $100 allowance; you pay the remaining balance with a 15% discount
• Elective Disposable lenses	**Plan pays** $100 allowance; you pay the remaining cost
• Non-Elective Contact lenses	**Plan pays** full cost

Elective contact lenses are in lieu of eyeglass lenses (frames and lenses). Non-elective lenses are covered when glasses are not an option for vision correction.

Contact lens fitting and follow-up
A contact lens fitting, and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.

Standard contact fitting — you pay up to $55
A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement lenses.

Premium contact lens fitting — you pay the cost with a 10% discount
A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal lenses.

Additional Savings on Eyewear and Accessories
After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories at Blue View Vision network Providers at any time. The Calendar Year restriction does not apply. Blue View Vision's Additional Savings Program is subject to change without notice.

Service:	Your Discount:
• Additional complete pair of eyeglasses (as many as you like)	40% off retail
• Conventional Contact Lenses (materials only)	15% off retail
• Additional Eyewear & Accessories (Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eyeglass cases, lens cleaning supplies, contact lens solutions, etc.)	20% off retail

Out-of-Network Benefits

You can choose to receive care outside of the Blue View Vision network. The following allowances apply to out-of-network coverage. You pay any cost above the allowance.

Service:	Out-of-Network Allowance:
• Routine eye exam	$40 allowance
• Eyeglass frames	$80 allowance
• Standard plastic single vision lenses (1 pair)	$50 allowance
• Standard plastic bifocal lenses (1 pair)	$75 allowance
• Standard plastic trifocal lenses (1 pair)	$100 allowance
• Elective conventional and disposable lenses	$80 allowance
• Non-Elective Contact lenses	$210 allowance
• Standard Progressive Lenses	$75 allowance

You will need to pay for covered services and purchases at the time of your visit, and send an out-of-network claim form and itemized receipt to Blue View Vision for reimbursement. The claim form is available at **www.anthem.com/tlc** under Resources and Forms.

Exclusions

In addition to the dental and vision exclusions listed in this insert, all applicable “Exclusions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert.

Basic Plan Provisions

All applicable “Basic Plan Provisions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the dental and vision benefits described in this insert.

Definitions

All applicable “Definitions” listed in the Medicare-Coordinating Plans Member Handbook also apply to the Dental/Vision benefits described in this insert. The following definition differs under these Dental/Vision benefits described in this insert from the definition in the Member Handbook:

Participating and Non-Participating Providers

For this vision coverage, a Participating Provider is a Provider who is listed as a “Participating Blue View Vision Provider” by the Claims Administrator. A Provider who does not participate inthe Blue View Vision network is not a Participating Provider.

For this dental coverage, Participating Providers are dentists who have signed a written provider service agreement with Anthem agreeing to service the Complete dental program.

Eligibility

Eligibility information listed in the Medicare-Coordinating Plans Member Handbook also applies to the Dental/Vision benefits described in this insert.

Commonwealth of Virginia's Health Benefits Programs Nondiscrimination Notice

The State and Local Health Benefits Programs of the Department of Human Resource Management (the "Health Plan"), sponsored by the Commonwealth of Virginia (the "Commonwealth") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- 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 (such as large print, audio, 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 Office of Health Benefits Programs.

If you believe that the 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:

Office of Health Benefits Programs
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219-3657
Please mark the envelope - Confidential

To use email, send your complaint to appeals@dhrm.virginia.gov

To use facsimile, fax your complaint to 804-786-0356.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Health Benefits Program 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, 800-537-7697 (TDD)

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

2025-26 Language Assistance Statement

State Health Benefits Program

Virginia Department of HUMAN RESOURCE MANAGEMENT

The Commonwealth of Virginia's State and Local Health Benefits Programs (the "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. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to appeals@dhrm.virginia.gov or fax to 804-786-0356.

Spanish:
ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para appeals@dhrm.virginia.gov~~V o por fax al 804-786-0356.

Korean:
주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 appeals@dhrm.virginia.gov~~V하는 지원이나 팩스에 대한 요청을 보냅니다.

Vietnamese:
Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ đẻ appeals@dhrm.virginia.gov~~V hoặc fax 804-786-0356.

Chinese:
注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。發送您的語言協助 appeals@dhrm.virginia.gov~~V或傳真至804-786-0356請求。

Arabic:
تنبيه: إذا كنت بحاجة إلى مساعدة باللغة التي تتحدثها، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا.
أرسل طلبك للحصول على المساعدة اللغوية عبر البريد الإلكتروني إلى appeals@dhrm.virginia.gov
أو عبر الفاكس إلى 804-786-0356.

Persian:
توجه: اگر شما نیاز به کمک در زبان شما صحبت می کنند، خدمات کمک زبان در دسترس شما هستند رایگان می باشد. ارسال درخواست خود را برای کمک به زبان appeals@dhrm.virginia.gov~~V.0356-786-804 یا فکس به

Amharic:
አዳምጥ: አንተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ ,የ ቋንቋ እርዳታ አገ ልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚ ኙ ና ቸው. 804-786-0356 ቋንቋ appeals@dhrm.virginia.gov~~V እርዳታ ወይም በ ፋክስ ጥያ ቄዎን ይላ ኩ.

Urdu:
توجہ فرمائیں: اگر آپ کو اپنی بولی جانے والی زبان میں مدد درکار ہے تو زبان میں مدد کی خدمات آپ کے لیے بالکل مفت دستیاب ہیں۔
زبان میں مدد کے لیے اپنی درخواستیں appeals@dhrm.virginia.gov پر بھیجیں یا 804-786-0356 پر فیکس کریں۔

French:
ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour appeals@dhrm.virginia.gov~~V ou par télécopieur au 804-786-0356.

Russian:
ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к appeals@dhrm.virginia.gov~~HEAD=pobj~~V или по факсу 804-786-0356.

Hindi:
ध्यान दें: यदि आपको उस भाषा के लिए मदद की ज़रूरत है, जिस भाषा में आप बात करते हैं, तो आपके लिए भाषा सहायता सेवाएं निशुल्क में उपलब्ध हैं। भाषा की सहायता के लिए अपना अनुरोध appeals@dhrm.virginia.gov पर या फ़ैकस के लएि 804-786-0356 पर भेजें।

German:
ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.

Bengali:
দৃষ্টি আকর্ষণ: আপনি ভাষা আপনি কথা বলতে সাহায্য প্রয়োজন হয়, তাহলে ভাষা সহায়তা সেবা নিখরচা আপনার জন্য উপলব্ধ. appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্স ভাষা সহায়তা 804-786-0356 করার জন্য আপনার অনুরোধ পাঠান.

Bassa:
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ́ìn m̀ ké gbo kpáa. Đá 804-786-0356.

Igo (Igbo):
Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.

Yoruba:
Akiyesi: Ti o ba nilo iranlọwọ ninu ede ti o sọrọ, ede iranlowo iṣẹ ni o wa wa si o free ti idiyele. Fi ìbéèrè rẹ fun ede iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.

Filipino (Tagalog):
Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-786-0356.