



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, <https://eoc.anthem.com/eocdps/ca/aso>. 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/ or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$2,500 /individual or \$3,300 /participant within a family or \$5,000 /family for <u>Network Providers</u> . \$5,000 /individual or \$6,600 /participant within a family or \$10,000 /family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> for <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$4,000 /individual or \$8,000 /family for <u>Network Providers</u> . \$8,000 /individual or \$16,000 /family for Non- <u>Network Providers</u> .	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.
What is not included in the <u>out-of-pocket limit</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> .
Will you pay less if you use a <u>network provider</u>?	Yes, Blue Card PPO. See www.anthem.com/ca or call (844) 451-2077 for a list of <u>network 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 out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Free-standing Facility: 20% coinsurance after deductible Outpatient Hospital: \$25 co-payment/visit after deductible + 20% coinsurance after deductible	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	Radiology Center: 20% coinsurance after deductible Outpatient Hospital: \$100 co-payment/visit after deductible + 20% coinsurance after deductible	40% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	Retail (30 days): \$15 co-payment after deductible Optum Rx Mail Order: \$37.50 co-payment after deductible	Not covered	For a list of In- <u>network</u> retail and mail pharmacies, log on to www.optumrx.com or call 1-888-850-5269.

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.optumrx.com .	Tier 2 - Typically <u>Preferred</u> / Brand	Retail (30 days): \$35 co-payment after deductible Optum Rx Mail Order: \$87.50 co-payment after deductible	Not covered	Retail: Up to ninety (90) day supply. CVS Retail: 2.5x 30-day copayment. Non-CVS Retail: 3x 30-day copayment. Optum Rx Mail Order: Limited to ninety (90) day supply.
	Tier 3 - Typically Non- <u>Preferred</u>	Retail (30 days): \$60 co-payment after deductible Optum Rx Mail Order: \$150 co-payment after deductible	Not covered	Co-payments are per prescription. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.optumrx.com .
	Tier 4 - Typically <u>Specialty</u> (brand and generic)	20% coinsurance after Deductible (up to \$200)	Not covered	Pre-authorization is required for some specialty drugs. Failure to obtain pre-authorization will result in a denial of benefits unless retroactive review of services proves medical necessity. Optum® Specialty Pharmacy will be your exclusive specialty pharmacy. If you use a copay card, the amount covered by the copay card will not go toward your deductible or out-of-pocket limit. Only what you pay out-of-pocket counts toward that.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$600 per day maximum allowed amount for non-network providers. Plan participants are responsible for 30% of this \$600 per day, plus all charges in excess of \$600. Pre-certification is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$100 co-payment/visit after deductible + 20%	\$100 co-payment/visit after deductible + 20%	Copay waived if admitted. 20% <u>coinsurance</u> for Emergency Room Physician Fee.

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		coinsurance after deductible	coinsurance after deductible	
	<u>Emergency medical transportation</u>	20% coinsurance after deductible	20% coinsurance after deductible	-----none-----
	<u>Urgent care</u>	20% coinsurance after deductible	40% coinsurance after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 co-payment/visit after deductible + 20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	\$600 maximum/day for Non- <u>Network Providers</u> . Pre-certification is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <u>coinsurance</u> Other Outpatient 20% <u>coinsurance</u>	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	Other Outpatient \$600 maximum/day for Non- <u>Network Providers</u> . Pre-certification is required for intensive outpatient and partial hospitalization.
	Inpatient services	\$100/visit then 20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$600 maximum/day for Non- <u>Network Providers</u> . 20% <u>coinsurance</u> for Inpatient Physician Fee <u>Network Providers</u> . 40% <u>coinsurance</u> for Inpatient Physician Fee Non- <u>Network Providers</u> . Pre-certification is required
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, <u>co-insurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). \$600 maximum/day for Non- <u>Network Providers</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$100/visit then 20% <u>coinsurance</u>	40% <u>coinsurance</u>	

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days limit/benefit period for <u>network</u> and non- <u>network</u> services combined. Pre-certification is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Rehabilitation services are limited to physical, occupational, speech and respiratory therapies. 90 visits per benefit period /Physical, Occupational and Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days limit/benefit period – in-network and out-of-network combined. \$600 maximum/day for Non- <u>Network</u> Outpatient Hospital Services. Pre-certification is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Respite care maximum: 5 consecutive days limit/per confinement.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental Check-up
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Eye exams for a child
- Private-duty nursing
- Non-emergency care when traveling outside the U.S
- Dental care (adult)
- Glasses for a child
- Routine eye care (adult)
- Weight loss programs

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

- Abortion
- Acupuncture 20 visits/benefit period.
- Bariatric surgery
- Chiropractic care 20 visits/benefit period.
- Infertility treatment - covered through Kindbody
- Hearing aids \$3,000 maximum/benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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 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:

ATTN: Grievances and Appeals, PO Box 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes/No

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes/No

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.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

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

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	20%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$3,570

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	20%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,400

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	20%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,590

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 333-5730

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5730 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5730.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5730:

Bassa (Bàsɔ̀ wùdù): M̐ dyi dyi-diè-dɛ̀ b̐é b̐édé b̐á céè-dɛ̀ n̐à kɛ dyí ní, ɔ̀ m̐ò n̐ì dyí-b̐édɛ̀n-dɛ̀ b̐é m̐ kɛ gbo-kpá-kpá kè b̐ŋ kpɔ̀ dɛ̀ m̐ bídɛ̀-wùdùùn b̐ó pídyi. B̐é m̐ kɛ wuɖu-zìin-nyò d̐ò gbo wùdù kɛ, d̐á (855) 333-5730.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5730 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5730 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5730。

Dinka (Dinka): Na n̐ɔŋ thiëc n̐e ke de yā thorë, ke yin n̐ɔŋ loŋ b̐ë yi kuony ku w̐er alëu b̐ë g̐ɛɛr yic yin ne thoŋ du ke cin w̐ëu t̐äüë ke piny. Te k̐or yin ba jam w̐ënë ran ye thok geryic, ke yin c̐ol (855) 333-5730.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 333-5730.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5730 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5730.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 333-5730.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5730.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 333-5730.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5730.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 333-5730 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 333-5730.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5730.

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Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5730

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Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 333-5730.

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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 333-5730.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bína'idíłkídgó ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo báááh ilínígóó.
Ata' halne'ígíí lá' bich'í' hadeesdzih nínízingo kojí' hodiílnih (855) 333-5730.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 333-5730

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