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. For your Pharmacy benefits through Express-Scripts (Medco) go to www.express-scripts.com or call 1-877-554-3091.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Primary Care. Specialist Visit. Preventive Care. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500/person or $4,500/family for In-Network Providers. Prescription (Only In-network Providers): $5,100/person or $8,700/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription Drug cost share out-of-network, any member prescription penalties (if applicable), premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=JPU or call (855) 333-5730 for a list of network providers. Costs may	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.

	vary by site of service and how the provider bills.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	$25/visit	Not covered	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25/visit	Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	$25/visit	Not covered	--------none--------
Pharmacy OOPM	Out of Pocket Maximum (OOPM)	$5,100 Per Person/$8,700 Per Family	Non-Network claims do not apply to the OOPM	Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	$10 Co-pay (retail) $20 Co-pay (mail order)	$10 Co-pay (retail) Not Covered for mail order scripts	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).

* For more information about limitations and exceptions, see the 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 2 - Typically Preferred / Brand	$25 Co-pay (retail) $45 Co-pay (mail order)	$25 Co-pay (retail) Not Covered for mail order scripts	For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs. For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill. Prior Authorization / Coverage Management programs may apply to some drugs 90 day supply for maintenance medication available through Express Scripts, Walgreens and CVS. Although 90 day supplies are encouraged, members may continue filling 30-day supplies of any medication at any in-network retail pharmacy without penalty; however the broad retail pharmacy network is limited to dispensing a 30-day supply. Out of Pocket Maximum (OOPM) Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$55 Co-pay (retail) $95 Co-pay (mail order)	$55 Co-pay (retail) Not Covered for mail order scripts	
	Tier 4 - Typically Specialty (brand and generic)	Follows tier copays	Not covered	

* For more information about limitations and exceptions, see the 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/visit	Not covered	--------none--------
	Physician/surgeon fees	0% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	$75/admission	Covered as In-Network	Copayment waived if admitted. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	$50/trip	Covered as In-Network	Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per trip.
	Urgent care	No charge	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission	Not covered	--------none--------
	Physician/surgeon fees	0% coinsurance	Not covered	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit Other Outpatient $250/visit	Office Visit Not covered Other Outpatient Not covered	Office Visit 988 lifeline/mobile crisis team covered as In-Network. Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	$250/admission	Not covered	0% coinsurance for Inpatient Physician Fee In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	$25/visit	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	0% coinsurance	Not covered	
	Childbirth/delivery facility services	$250/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance (1 - 30 visits), then $25/visit thereafter	Not covered	--------none--------
	Rehabilitation services	$25/visit	Not covered	*See Therapy Services section.
	Habilitation services	$25/visit	Not covered	
	Skilled nursing care	$250/visit	Not covered	100 days/benefit period for skilled nursing services for In-Network Providers.

* For more information about limitations and exceptions, see the 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	0% coinsurance	Not covered	*See Durable Medical Equipment section.
	Hospice services	$250/admission	Not covered	$5,000 maximum/lifetime for In-Network Providers.
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--------

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.)

- Acupuncture
- Cosmetic surgery
- Glasses for a child
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes
- Children's dental check-up
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Chiropractic care
- Eye exams for a child
- Infertility treatment
- Routine eye care (Adult)

Pharmacy Benefit Exclusions

- Allergy Serums
- Drugs used to promote or stimulate hair growth
- Non-Federal Legend Drugs
- Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual
- ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age
- ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over
- Biologicals
- Blood or blood plasma products
- Nutritional Supplements
- Some or certain compounds are excluded
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- Drugs used for cosmetic purposes
- Insulin Pumps
- Ostomy Supplies
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Fluoride-Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years

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

- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- Certain formulary exclusions apply, for more information on this as well as the latest drug coverage please visit our website www.express-scripts.com
- ACA Preventive Meds – Statins Exception: Covered for adults 40-75 years of age

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

- Bariatric surgery
- Private-duty nursing in a Home Setting only
-

Other Pharmacy Benefit Inclusions

- Specialty Drugs
- Insulin
- OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products)
- ACA Preventive Meds Aspirin – Exception: covered for adults under 70 years of age
- ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over
- ACA Preventive Meds - Statins Exception: Covered for adults 40-75 years of age
- State Restricted Drugs
- Needles and Syringes
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- Vaccines
- Drugs to treat Impotency for males only age 18 and over
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- ACA Preventive Meds Fluoride -Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds HIV – Exception: Covered for Generic Only

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

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: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357) , Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. 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 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:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, 300 South Spring Street, 14th Floor, Los Angeles, CA 90013, 800-927-4357, 800-482-4833 (TTY), https://www.insurance.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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

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 plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other copayment	**$25**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$770**

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

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other copayment	**$25**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$250**
Other copayment	**$25**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$410**

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 1-888-254-2721

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-888-254-2721 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 1-888-254-2721 .

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՝ 1-888-254-2721:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá 1-888-254-2721.

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 1-888-254-2721 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခွက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု 1-888-254-2721 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1-888-254-2721。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl 1-888-254-2721.

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 1-888-254-2721.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721 ।

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 1-888-254-2721.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 1-888-254-2721.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi 1-888-254-2721.

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 1-888-254-2721

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには 1-888-254-2721 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ1-888-254-2721 ។

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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

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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 1-888-254-2721

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