### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Anthem® Blue Cross Life and Health Insurance Company**  
**PRISM (City of Santa Rosa): Custom EPO 5**

Coverage Period: 01/01/2023 - 12/31/2023  
Coverage for: Individual + Family | Plan Type: EPO

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/aso](https://eoc.anthem.com/eocdps/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/](https://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](https://www.express-scripts.com) or call 1-877-554-3091.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500/person or $4,500/family for In-Network Providers. Prescription (Only In-network Providers): $5,100/person or $8,700/family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>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.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, EPO. See <a href="https://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of network providers. Costs may vary by site of service and how the provider bills.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>$25/visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Non-Network Provider (You will pay the most)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>In-Network Provider (You will pay the least)</td>
<td>$25/visit</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Network Provider (You will pay the most)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Pharmacy OOPM</strong></td>
<td>Out of Pocket Maximum (OOPM)</td>
<td></td>
<td>$5,100 Per Person/$8,700 Per Family</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Typically Generic</td>
<td></td>
<td>$10 Co-pay (retail)</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Brand</td>
<td></td>
<td>$10 Co-pay (mail order)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not Covered for mail order scripts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$25 Co-pay (retail)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$45 Co-pay (mail order)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not Covered for mail order script</td>
</tr>
<tr>
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<td>Services You May Need</td>
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<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td></td>
<td>In-Network Provider (You will pay the least): $55 Co-pay (retail) $95 Co-pay (mail order)</td>
<td>Non-Network Provider (You will pay the most): $55 Co-pay (retail) Not Covered for mail order script</td>
</tr>
<tr>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td></td>
<td>Follows tier copays</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$75/admission</td>
<td>Covered as In-Network Copay waived if admitted. No charge for Emergency Room Physician Fee.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50/trip</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250/admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Inpatient services</td>
<td>$250/admission</td>
<td>Not covered</td>
<td>No charge for Inpatient Physician Fee In-Network Providers. No Coverage for Inpatient Physician Fee Non-Network Providers.</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td>*Coverage includes fertility preservation services, see Fertility Preservation section.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250/admission</td>
<td>Not covered</td>
<td>100 days/benefit period for skilled nursing services for In-Network Providers.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>No charge (1 - 30 visits), then $25/visit thereafter</td>
<td>Not covered</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25/visit</td>
<td>Not covered</td>
<td>100 days/benefit period for skilled nursing services for In-Network Providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$25/visit</td>
<td>Not covered</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>$250/visit</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>No charge</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>$250/admission</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Children’s eye exam</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>$5,000 maximum/lifetime for In-Network Providers.</td>
</tr>
</tbody>
</table>

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

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
## 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
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 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
- Certain formulary exclusions apply, for more information on this as well as the latest drug coverage please visit our website [www.express-scripts.com](http://www.express-scripts.com)
- 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
- ACA Preventive Meds – Statins

## 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

## Pharmacy Benefit Exclusions

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* For more information about limitations and exceptions, see [plan](#) or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
• ACA Preventive Meds – Vitamin D
  Exception: Covered for adults age 65
  years of age and over

• ACA Preventive Meds – Statins
  Exception: Covered for adults 40-75 years
  of age

• Certain formulary exclusions apply, for
  more information on this as well as the
  latest drug coverage please visit our
  website www.express-scripts.com

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. 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


California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), 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 plan or policy document at https://eoc.anthem.com/coedps/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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$25</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$250</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$25</td>
<td>Other copayment</td>
</tr>
</tbody>
</table>

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:
- Deductibles $0
- Copayments $700
- Coinsurance $0
- What isn’t covered: $70
- The total Peg would pay is $770

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:
- Deductibles $0
- Copayments $400
- Coinsurance $0
- Limits or exclusions $4,300
- What isn’t covered: $70
- The total Joe would pay is $4,700

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:
- Deductibles $0
- Copayments $400
- Coinsurance $0
- Limits or exclusions $10
- What isn’t covered: $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 gjihën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-888-254-2721.

Amharic (አማርኛ): እነወ ከወያ ታማንኛውም ከም ትው በም ትው በም ትው በም ትው በም ትው በም ት-counterfeit በም ትው በም ትው በxygen የማስተርጓሚ 1-888-254-2721 የደበወ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المنشور، فهناك في نفسي مساعدة والمعلومات بأسعار تنافسية. للتحدث إلى المترجم، اتصل على 1-888-254-2721.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721:

Bassa (Bàssò Wùdù): Ì m dëy-dìe-dè bë bëdë bá çée-dë nià ke dyi ni, o mò nì dyì-bëdë-dë bë m ké gbo-kpá-kpá kë bò kpô dë m biñ-wùdùùn bò pidyi. Bë m ké wùdù-zini-nyö dò gbo wùdù ke, dà 1-888-254-2721.

Bengali (বাংলা): যদি এই লিপিতে বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়া ও জ্ঞান পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা কথার জন্য 1-888-254-2721 -তে কল করুন।

Burmese (ဗာသား): မိုးလေးလေးလေး လက်လီလက်လီလာ ထွန်းကြောင်း မိုးလေးလေးလေး လက်လီလီလာ ထွန်းကြောင်း မိုးလေးလေးလေး လက်လီလီလာ ထွန်းကြောင်း 1-888-254-2721

Chinese (中文): 如果您对本文件有任何疑问，您有权利使用您的语言免费获得协助和资讯。如需与译员通电话，请致电1-888-254-2721。

Dinka (Dinka): Na nang thièce nè ke de yà thòrè, ke yim nang loj bè yi kuony ku wér ałów bè gèez yiè yim ne thòng du ke cin wèn tààuè ke piny. Te kòx yin ba jay wènè ra ya thok geryic, ke yin col 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 (فارسی): در صورتی که سوالی پربرامون این سنند دارید، این حق را دارید که اطلاعات و کمک را بدون هزینه‌ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شافاهی، با شماره 1-888-254-2721-1 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.

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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 દસ્તાબેજ અંગે આપને કોઈપણ પ્રશ્ન કરતા હોય તો, કોઈપણ બાર આપની ભાષામાં M44 અને મહિલા મેળવવાનો તમને અધિકાર છે. દુભાષિણય 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 (हिन्दी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको निश्चित अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें 1-888-254-2721.


Igbo (Igbo): Ọ bụ ọụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, i nwere irike ịnweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ ọ bụla. Ka gi na okowa okwu kwuo okwu, kpon 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 maya nga tagipatarus, awangan ti 1-888-254-2721.

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Language Access Services:

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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 1-888-254-2721.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-888-254-2721 로 문의하십시오.

Lao (ລາວ): ໂດຍធ្វើជាមួយក្រុមហ៊ុននេះដោយប្រឈមជាមួយត្រឹមត្រូវ ឬដោយប្រឈមជាមួយប្រឈមដែលអ្នកចង់ ។ ដើម្បីទូទៅជាមួយសេវាកម្មអនក ការទូទាត់ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos biká’iigu lahgo bina’idlikidgo ná bohonnéé’ doó bee ahóó’i’ t’áá ni nízaad k’ehjí bee nił hodoonih t’áadoo bááh ilinigóó. Ata’ halne’igí’ la’ bich’jí’ hadeesdzíh nínízingko ko’jí hodilníh 1-888-254-2721.

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