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

Coverage Period: 07/01/2021 - 06/30/2022
Coverage for: Individual + Family | Plan Type: Indemnity

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) 634-3383 to request a copy.

### Important Questions | Answers | Why This Matters:
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**What is the overall deductible?** | $500/person or $1,000/family for In-Network Providers, $500/person or $1,000/family for Non-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**Are there services covered before you meet your deductible?** | Yes. Preventive Care for In-Network and Non-Network Providers. | 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/](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?** | $3,000/person or $6,000/family for In-Network Providers, $3,000/person or $6,000/family for Non-Network Providers. | 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?** | Services deemed not medically necessary by Medical Management and/or Anthem, 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?** | Not Applicable. | This plan does not use a provider network. You can receive covered services from any provider.
Do you need a **referral** to see a **specialist**?

No. You can see the specialist you choose without a referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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<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): 20% <strong>coinsurance</strong></td>
<td>Non-Network Provider (You will pay the most): 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/Immunization</td>
<td>No charge</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>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Generic</td>
<td>20% <strong>coinsurance</strong> (30-day Rx) 10% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.express-scripts.com">http://www.express-scripts.com</a></td>
<td>Tier 2 - Preferred Brand</td>
<td>40% <strong>coinsurance</strong> (30-day Rx) 30% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Non-Preferred Brand</td>
<td>50% <strong>coinsurance</strong> (30-day Rx) 40% <strong>coinsurance</strong> (90-day Rx at UK Pharmacy or Express Scripts Home Delivery)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty Generic</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty Brand</td>
<td>$200 per 30 day Rx</td>
<td>Not covered</td>
</tr>
<tr>
<td>Separate pharmacy out-of-pocket limits apply. Single-$4,900 Family-$9,800</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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).
<table>
<thead>
<tr>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>In-Network Provider (You will pay the least) $100/visit then 20% coinsurance deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Non-Network Provider (You will pay the most)</td>
<td>Copay waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>100 visits/benefit period</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>100 days/benefit period for skilled nursing services.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>20% coinsurance</td>
<td>*See Vision Services section</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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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.):

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered).
- Dental care (Pediatric)
- Infertility treatment
- Routine eye care (Adult)
- Tier 2 - Typically Preferred / Brand
- Specialty Brand
- Cosmetic surgery
- Dental Check-up
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Tier 3 - Typically Non-Preferred / Specialty Drugs
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Private-duty nursing
- Tier 1 - Typically Generic
- Specialty Generic

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

- Acupuncture 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and manipulative treatment.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Bariatric surgery
- Spinal Manipulation 45 visits/benefit period for physical therapy, occupational therapy, speech therapy, Cardiac therapy, and Acupuncture.
- Hearing aids one/ear every 36 months under age 18.

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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, 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 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 105568, Atlanta GA 30348-5568


* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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/eocdps/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><em>(9 months of in-network pre-natal care and a hospital delivery)</em></td>
<td><em>(a year of routine in-network care of a well-controlled condition)</em></td>
<td><em>(in-network emergency room visit and follow up care)</em></td>
</tr>
<tr>
<td>- The <strong>plan’s overall deductible</strong> $500</td>
<td>- The <strong>plan’s overall deductible</strong> $500</td>
<td>- The <strong>plan’s overall deductible</strong> $500</td>
</tr>
<tr>
<td>- <strong>Specialist coinsurance</strong> 20%</td>
<td>- <strong>Specialist coinsurance</strong> 20%</td>
<td>- <strong>Specialist coinsurance</strong> 20%</td>
</tr>
<tr>
<td>- <strong>Hospital (facility) coinsurance</strong> 20%</td>
<td>- <strong>Hospital (facility) coinsurance</strong> 20%</td>
<td>- <strong>Hospital (facility) coinsurance</strong> 20%</td>
</tr>
<tr>
<td>- <strong>Other coinsurance</strong> 20%</td>
<td>- <strong>Other coinsurance</strong> 20%</td>
<td>- <strong>Other coinsurance</strong> 20%</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)*

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)*

This EXAMPLE event includes services like:
- **Emergency room care** *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, **Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$500</th>
<th>$0</th>
<th>$2,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60

The **total Peg would pay** is $2,960

In this example, **Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$500</th>
<th>$0</th>
<th>$1,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $20

The **total Joe would pay** is $2,220

In this example, **Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$500</th>
<th>$100</th>
<th>$400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

The **total Mia would pay** is $1,000

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 përkkthyes, telefononi (855) 634-3383

Amharic (አማርኛ): ከአማርኛ ይምር የተነገር የሚቀር የተከስ ያሸጥ ይታለባል ከአማርኛ ይታለባል ይታለባል ያሸጥ ያሸጥ ይታለባል ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸጥ ያሸ.stringify().split(').join('').includes(' EditText') (855) 634-3383

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فممكن لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 634-3383.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկություններ: Թարգմանչի հետ խոսելու համար զանգահարեք (855) 634-3383:

Basa (Bàsà wòò): M dyi dyi-die-dè bë bëcé bë cè nià ke diy ni, c mò ni dyi-bèqè-èn-dë bë m ke gbo-kpá-kpá kë bò kpö dë m bîdi-wùwuùn bô pidy. Bè m ke wùwu-zin-nyo dò gbo wùwu ke, dà (855) 634-3383.

Bengali (বাংলা): যদি এই লিপিতের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলায়তী সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন দৌড়াঘারের সাথে কথা বলা জন্য (855) 634-3383 -ভাষায় কথা বলা।

Burmese (မြန်မာ): မြန်မာလူမျိုးသားလူမျိုး နိမိတ် အိုင်းအိုင်း စွဲချောင်း သင့်တော်လှန်ရေး သဘာဝအိုင်း ကြည်မှု အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အဆင့်မှာ သရဖြင့် အ标准化 (855) 634-3383

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Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અને આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ વગર આપની ભાષામાં મધ્ય અને માહિતી મેળવવા તમને અધિકાર છે. ફ્રી સાથે વાત કરવા માટે, કોલ કરો (855) 634-3383.

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Hindi (हिंदी): यदि आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 634-3383.


Igbo (Igbo): Ọ bụrụ na i nwere ajụju ọ bula gbasara akwụkwọ a, i nwere ịkike ịnweta enyemaka na ozi n'asụsụ ị na akwụgbị ụgwọ ọ bula. Ka ị na ọkwọ okwu kwuo okwu, kpọọ (855) 634-3383.

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(855) 634-3383

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) 634-3383.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 634-3383 로 문의하십시오.

Lao (ພາສາລາວ): តូល្យាយឹងមួយចំនួនវេបាការប្រសិនបើការអនុម័តសម្រាប់ការចុញការពារវាងក្រុងនីមួយៗ និងអត្ថប្រយោជន៍នៃប្រព័ន្ធឤេស្រី។
(855) 634-3383.

Navajo (Diné): Díí naalssoos biká’ígíí lahgo bina’idiikidgo ná bobiíbáží dóó bee ahóó’tí’í t’áá ni níazz k’ehí bee nił hodoonih t’áadoo báá’h ilíngóó. Ata’ halne’ígíí la’ bíchí’i hadesdizhi ninízingo kojjí hodiilnhí (855) 634-3383.

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(855) 634-3383

Oromo (Oromiffa): Sanadi kanaa wajiin waqlabate gaffi kamiyu yoo qabduu tanaan, Gargaarsa argachuuf fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 634-3383 bilbilla.


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**Yoruba (Yorùbá):** Ò tó bá ní ìyíkèyí ìberè nípa àkọsilè yìí, ò ní ètò ètì gbà àrànwò àtì ìwííún ní èdè ře lójìì. Bá wa ọgbùfù kan sòrò, pe (855) 634-3383.
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