




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, go to hr2.chevron.com or

contact the Chevron Human Resources Service Center at 1-888-825-5247 (1-832-854-5800 outside the U.S.). 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 1-844-627-1632 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	<p>For Medical, Prescription Drug, and Behavioral Health (Mental Health and Substance Use Disorder) combined.</p> <p>For network providers.</p> <p>\$5,000 You Only</p> <p>\$10,000 You and One Adult/\$5,000 Per Person</p> <p>\$10,000 You and Child(ren)/\$5,000 Per Person</p> <p>\$10,000 You and Family/\$5,000 Per Person</p> <p>For out-of-network providers.</p> <p>\$10,000 You Only</p> <p>\$20,000 You and One Adult/\$10,000 Per Person</p> <p>\$20,000 You and Child(ren)/\$10,000 Per Person</p> <p>\$20,000 You and Family/\$10,000 Per Person</p>	<p>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.</p>
Are there services covered before you meet your deductible ?	<p>Yes. Preventive care for network providers are covered before you meet your deductible. Deductible does not apply to certain preventive care in network services as specified by the Affordable Care Act.</p> <p>The following are a few major exceptions that do not count toward the deductible: charges in excess of contracted rate/allowed amount by an out-of-network provider (balanced billed charges); your share of costs and expenses under the Vision Program; charges that aren't covered or medically necessary under the plan; penalties for non-compliance; health care this plan doesn't cover; the difference between cost of generic and brand-name drug; the difference between the network and the out-of-network pharmacy price (including when you don't provide your ID card at a network pharmacy); charges that aren't covered by the plan.</p>	<p>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/.</p>

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 ?	<p>For Medical, Prescription Drug, and Behavioral Health (Mental Health and Substance Use Disorder) combined</p> <p>For network providers</p> <p>\$6,550 You Only \$13,100 You and One Adult/\$6,550 Per Person \$13,100 You and Child(ren)/\$6,550 Per Person \$13,100 You and Family/\$6,550 Per Person</p> <p>For out-of-network providers</p> <p>\$13,100 You Only \$26,200 You and One Adult/\$13,100 Per Person \$26,200 You and Child(ren)/\$13,100 Per Person \$26,200 You and Family/\$13,100 Per Person</p>	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 ?	The following are a few major exceptions that do not count toward the medical out-of-pocket limit : premiums ; difference between the cost of generic and brand name drugs; your share of costs and expenses under the Vision Program; charges that aren't deemed medically necessary under the plan ; penalties for failure to obtain pre-authorization for services; charges in excess of contracted rate/ allowed amount by an out-of-network provider (balance billed 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, BlueCard PPO. See www.anthem.com/ca or call 1-844-627-1632 for a list of network providers .	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.
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
		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	30% coinsurance	50% coinsurance	If you receive services in addition to an office visit, additional copayment , deductibles , or coinsurance may apply.
	Specialist visit	30% coinsurance	50% coinsurance	
	Preventive care/screening/immunization	No charge	50% coinsurance	Immunizations for travel not covered. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling Express Scripts at 1-800-987-8368 or going to www.express-scripts.com	Generic drugs	Retail: 30% coinsurance Mail Order: 30% coinsurance .	Retail: 30% coinsurance Mail order: Not covered.	Must meet the deductible before you plan will share in the cost of your medication. When you use an out-of-network retail pharmacy, you pay the approved retail price minus the required coinsurance/copayment for your prescription after an approved claim for reimbursement. Certain items identified by your plan as preventative care are covered in full and not subject to the copay or deductible amounts indicated. Covers up to 30 day supply (retail prescription); 90 supply (mail-order prescription). Your plan uses a preferred drug list, also referred to as a formulary , which identifies the status of covered drugs. Some drugs may require pre-authorization . If the necessary preauthorization is not obtained, the drug may not be covered. Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered.
	Preferred Brand drugs	Retail: 30% coinsurance Mail Order: 30% coinsurance .	Retail: 30% coinsurance Mail Order: Not covered	
	Non-Preferred Brand drugs	Retail: 30% coinsurance . Mail Order: 30% coinsurance	Retail: 30% coinsurance . Mail Order: Not covered	
	Specialty drugs	See Generic, Preferred brand, and Non-preferred brand drugs above for cost information.	Retail: Not covered. Mail order: Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<p>Your plan may limit the quantity of a covered drug.</p> <p>You pay the difference in cost if you request a brand name drug instead of its generic equivalent.</p> <p>Refills for Specialty Drugs only available through mail-order</p> <p>Certain specialty drug require first fill at Express Scripts specialty pharmacy (Accredo). For a list of these drugs, contact Express Scripts at 1-800-987-8368.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	30% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-notification is required. If you don't get pre-authorization , coinsurance amounts could be reduced.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Mental health, behavioral health, and substance use services apply to the Medical deductible and out-of-pocket maximum.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Pre-notification required; limited to 60 visits/calendar year; combined network and out-of-network . If you don't get pre-authorization , coinsurance amounts could be reduced.
	Rehabilitation services	30% coinsurance	50% coinsurance	90 visits combined maximum for physical, occupational and speech therapies per calendar year.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services .
	Skilled nursing care	30% coinsurance	50% coinsurance	Pre-notification required; 120 days per calendar year. If you don't get pre-authorization , coinsurance amounts could be reduced.
	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-notification required for any item with a purchase price or cumulative rental price above \$1,000. If you don't get pre-authorization , coinsurance amounts could be reduced.
	Hospice services	30% coinsurance	50% coinsurance	Pre-notification required. If you don't get pre-authorization , coinsurance amounts could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Benefits may be provided by the Chevron Corporation Vision Program. For more information, go to hr2.chevron.com , or call 1-800-877-7195 (1-916-851-5000 outside the U.S.).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up under this plan .

* For more information about limitations and exceptions, see the [plan](#) or policy document at hr2.chevron.com or call 1-888-825-5247 for a copy.

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](#).)

- | | | |
|---------------------------------|---|--|
| • Cosmetic surgery | • Habilitation services | • Routine eye care (adult and child) |
| • Dental Care (adult and child) | • Long term care | • Routine foot care unless you have been diagnosed with diabetes |
| • Glasses (adult and child) | • | • Weight loss programs |

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

- | | | |
|---|--|---|
| • Acupuncture 20 visits/calendar year | • Hearing aids \$5,000 maximum every 4 years | • Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com |
| • Bariatric surgery | • Family planning and infertility services \$60,000 maximum/lifetime - combined medical and prescription drugs | • Private Duty Nursing 1,000 hours or 120 days/calendar year |
| • Chiropractic care 20 visits/calendar year | | |

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, 1-866-444-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 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 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform

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.

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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	\$5,000
▮ Specialist copayment	30%
▮ Hospital (facility) coinsurance	30%
▮ Other coinsurance	30%

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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,360

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

▮ The plan's overall deductible	\$5,000
▮ Specialist copayment	30%
▮ Hospital (facility) coinsurance	30%
▮ Other coinsurance	30%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$5,760

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

▮ The plan's overall deductible	\$5,000
▮ Specialist copayment	30%
▮ Hospital (facility) coinsurance	30%
▮ Other coinsurance	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Where a conflict exists between this SBC and the [plan](#) document, the [plan](#) document controls.

Language Access Services:

Farsi (فارسی): 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 1-844-627-1632 تماس بگیرید.

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 1-844-627-1632.

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 1-844-627-1632.

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 1-844-627-1632.

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 1-844-627-1632.

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 1-844-627-1632.

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 1-844-627-1632 ।

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 1-844-627-1632.

Igbo (Igbo): O bụr ụ na i nwere ajuju o bụla gbasara akwụkwọ a, i nwere ikike inweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ o bụla. Ka gi na okọwa okwu kwuo okwu, kpọọ 1-844-627-1632.

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 1-844-627-1632.

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 1-844-627-1632.

Language Access Services:

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 1-844-627-1632

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、1-844-627-1632 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ 1-844-627-1632 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-844-627-1632.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-844-627-1632 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໄວ້ວົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-844-627-1632.

Navajo (Diné): Dii naaltsoos bika'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nı́ł hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí la' bich'ı́' hadeesdzih nínízingo kojı́' hodiílnih 1-844-627-1632.

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 1-844-627-1632

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-844-627-1632 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griegie in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-844-627-1632 aa.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-627-1632.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 1-844-627-1632.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-844-627-1632 ਤੇ ਕਾਲ ਕਰੋ।

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(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט 1-844-627-1632.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ́ẹ́. Bá wa ògbùfọ́ kan sọrọ́, pe 1-844-627-1632.

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