BlueCross BlueShield of Vermont A Dependent line of the low of the line is line in the line in the line is line in the line in the line is line in the line in

\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Coverage For: All 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://www.bluecrossvt.org/documents/280-318-platinum-gold-silver-bronze-certificate-2024. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at http://www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$4,000 individual / \$8,000 family stacked. <u>Co-insurance</u> and <u>co-payments</u> do not apply to the <u>deductible</u> .	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount each <u>plan</u> year 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> . Your <u>plan</u> year: 01/01/2024 through 12/31/2024.
Are there services covered before you meet your <u>deductible</u> ?	Yes, <u>preventive care</u> , office visits, <u>urgent care</u> , <u>emergency medical transportation</u> , dental class I, generic <u>prescription drugs</u> , pediatric vision	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>co-insurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other <u>deductibles</u> for specific services?	Yes. \$500 individual / \$1,000 family prescription drug <u>deductible</u> . Does not apply to generic drugs.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ?	\$9,300 individual <u>plan</u> . Family plans have an individual <u>out-of-pocket limit</u> of \$9,300 and \$18,600 family stacked. <u>Prescription drugs</u> : \$1,500 individual <u>plan</u> / \$3,000 family. Medical and prescription drug out-of- pocket limits are combined.	The <u>out-of-pocket limit</u> is the most you could pay in a <u>plan</u> year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	Premiums, <u>balance-billing</u> charges, adult vision care, adult dental services 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. See www.bluecrossvt.org/find-doctor or call (800) 255-4550 for a list of <u>network</u> providers.	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 <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). For certain <u>emergency services</u> and/or services at an in-network hospital or surgical center (as explained below), the maximum amount you may pay is the <u>plan</u> 's in <u>network cost-sharing</u> amount. In these circumstances, the providers cannot balance bill you. Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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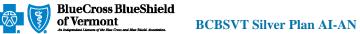
\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

All <u>co-payment</u> and <u>co-insurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Coverage Period Begins: 01/01/2024

Coverage For: All Plan Type: EPO

			XX71 / X7 XX7011		
Common Medical Event	Services You May Need	Native American# Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Primary care visit to treat an injury or illness	No charge	\$40 <u>co-payment</u> per visit for primary care physician and mental health / substance abuse	Not covered	Some services require <u>prior approval</u> . <u>Deductible</u> and <u>co-payments</u> do not apply to some services see www.bluecrossvt.org/standard-cert-2024 for more information. For clarification on mental health services visit www.bluecrossvt.org/members/coverage.
	<u>Specialist</u> visit	No charge	\$90 <u>co-payment</u> per visit	Not covered	Some services require <u>prior approval</u> .
If you visit a health care <u>provider</u> 's office or clinic	Other practitioner office visit	No charge	\$50 <u>co-payment</u> per visit for chiropractic care and outpatient physical therapy; \$90 <u>co-payment</u> per visit for nutritional counseling, outpatient speech and occupational therapy		Some services require <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	Preventive care/ Screening/ Immunization	No charge	No charge	Not covered	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. For clarification on <u>preventive services</u> visit www.bluecrossvt.org/members/coverage.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% <u>co-insurance</u> * for office-based and outpatient hospital	Not covered	Some services require prior approval.
n you nave a test	Imaging (CT/PET scans, MRIs)	No charge	50% <u>co-insurance</u> *	Not covered	Most services require prior approval.



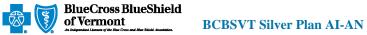
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\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2024

Coverage For: All Plan Type: EPO

			What You Will Pay		
Common Medical Event	Services You May Need	Native American# Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition. More information about <u>prescription drug</u> <u>coverage</u> is at www.bluecrossvt.org/ pharmacies- medications. This <u>plan</u> follows the National Performance Formulary (NPF).	Generic drugs	No charge	\$20 <u>co-payment</u> per prescription	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .
	Preferred brand drugs	No charge	\$500 <u>deductible</u> , then \$70 <u>co-payment</u> per prescription	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .
	Non-preferred brand drugs	No charge	\$500 <u>deductible</u> , then 50% <u>co-insurance</u>	Not covered	Covers up to a 30-day supply for most <u>prescription drugs</u> . Some prescriptions require <u>prior approval</u> .
	Wellness drugs	No charge	Wellness <u>prescription drugs</u> process the same as any other prescription.	Not covered	Covers up to a 30-day supply for most prescription drugs. Some prescriptions require prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> . If you see an <u>out-of-network provider</u> at an in- network facility, the most the <u>provider</u> may bill you is the in-network <u>cost-sharing</u> amount.
	Physician/surgeon fees	No charge	50% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> . If you see an <u>out-of-network provider</u> at an in- network facility, the most the <u>provider</u> may bill you is the in-network <u>cost-sharing</u> amount.



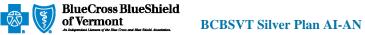
\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible

Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2024

Coverage For: All Plan Type: EPO

			What You Will Pay		
Common Medical Event	Services You May Need	Native American# Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	No charge	\$500 <u>co-payment</u> * per visit for facility services; no charge* for <u>physician</u> <u>services</u>	\$500 <u>co-payment</u> * per visit for facility services; no charge* for <u>physician services</u>	Must meet emergency criteria. If you have an <u>emergency medical condition</u> , and get <u>emergency services</u> from an <u>out-of-network</u> <u>provider</u> or facility, the maximum you may pay is the standard in-network <u>cost-sharing</u> amount and you cannot be balance billed.
	Emergency medical transportation	No charge	\$100 <u>co-payment</u> per member per day	\$100 <u>co-payment</u> per member per day	Must meet emergency criteria. If you have an <u>emergency medical condition</u> , and get <u>emergency services</u> from an <u>out-of-network</u> <u>provider</u> or facility, the maximum you may pay is the standard in-network <u>cost-sharing</u> amount and you cannot be balance billed.
	<u>Urgent care</u>	No charge	\$100 <u>co-payment</u> per visit	\$100 <u>co-payment</u> per visit	Applies to <u>urgent care</u> facilities. If you have an <u>emergency medical condition</u> , and get <u>emergency services</u> from an <u>out-of-network</u> <u>provider</u> or facility, the maximum you may pay is the standard in-network <u>cost-sharing</u> amount and you cannot be balance billed.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> . If you receive care from an <u>out-of-</u> <u>network provider</u> at an in-network hospital or ambulatory surgical center, the most the <u>provider</u> may bill you is the in-network <u>cost-</u> <u>sharing</u> amount and the <u>provider</u> cannot balance bill you.
	Physician/surgeon fees	No charge	50% <u>co-insurance</u> *	Not covered	Some services require <u>prior approval</u> . If you receive care from an <u>out-of-network provider</u> at an in-network hospital or ambulatory surgical center, the most the <u>provider</u> may bill you is the in-network <u>cost-sharing</u> amount and the <u>provider</u> cannot balance bill you.



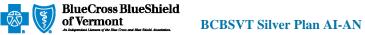
\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible

Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2024

Coverage For: All Plan Type: EPO

		What You Will Pay			
Common Medical Event	Services You May Need	Native American# Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need mental health, behavioral	Outpatient services	No charge	50% co-insurance*	Not covered	Some services require prior approval.
health, or substance abuse services	Inpatient services	No charge	50% co-insurance*	Not covered	Includes facility and physician fees. Requires prior approval.
If you are pregnant	Office Visits	No charge	\$40 <u>co-payment</u> (One <u>co-payment</u> covers all office visits by one <u>network</u> <u>provider</u>)	Not covered	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Depending on the type of services, a <u>co-payment</u> , <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.). For a list of services visit www.bluecrossvt.org/members/coverage.
	Childbirth/delivery professional services	No charge	50% co-insurance*	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .
	Childbirth/delivery facility services	No charge	50% <u>co-insurance</u> *	Not covered	Out-of-state inpatient care requires <u>prior</u> <u>approval</u> .



\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible

Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Coverage Period Begins: 01/01/2024

Coverage For: All Plan Type: EPO

			What You Will Pay		
Common Medical Event	Services You May Need	Native American# Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	50% <u>co-insurance</u> *	Not covered	Home infusion therapy requires <u>prior</u> <u>approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	Rehabilitation services	No charge	50% <u>co-insurance</u> * inpatient; cardiac / pulmonary services 50% <u>co-</u> <u>insurance</u> *	Not covered	Inpatient <u>rehabilitation services</u> require <u>prior</u> <u>approval</u> .
	Habilitation services	No charge	50% <u>co-insurance</u> * for inpatient services	Not covered	Requires <u>prior approval</u> . Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined.
	Skilled nursing care (facility)	No charge	50% co-insurance*	Not covered	Requires <u>prior approval</u> .
	Durable medical equipment (including supplies)	No charge	50% co-insurance*	Not covered	May require prior approval.
	Hospice	No charge	50% co-insurance*	Not covered	None
If your child needs dental or eye care	Eye exam	No charge	\$20 <u>co-payment</u> per child exam; 100% of charges for adult exam	Not covered	One routine exam per calendar year.
	Glasses	No charge	\$20 <u>co-payment</u> for child glasses; 100% of charges for adult glasses	Not covered	One pair of exchange-level frames and lenses for prescription glasses or one pair of equivalent contact lenses per calendar year.
	Dental check-up	No charge	Child: Class I: No charge, Class II: 30% <u>co-</u> <u>insurance</u> *, Class III: 50% <u>co-insurance</u> * Adult: 100% of charges	Not covered	Some services require <u>prior approval</u> . <u>Deductible</u> does not apply to Preventive fluoride supplements for children with non- fluoridated drinking water.

\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics) **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan</u> document for more infor	rmation and a list of any other <u>excluded services</u> .)
Acupuncture	 Cosmetic Surgery (except with prior approval reconstruction) 	for • Dental care (age 21 and older)
 Infertility Medications 	Long-term care	• Routine eye care (age 21 and older)
• Routine foot care (except for treatment of diabetes)	Weight loss programs	
Other Covered Services (Limitations may apply t	to these services. This isn't a complete list. Please se	ee your <u>plan</u> document.)
 Other Covered Services (Limitations may apply 1 Abortion 	 Bariatric surgery 	 Chiropractic care (requires prior approval after 12 visits)

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's Employee Benefits Security Administration at (866) 444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>, or the Department of Health and Human Services at (877) 267-2323 x61565 or <u>www.cciio.cms.gov</u>. You may also contact the <u>plan</u> at (800) 247-2583. Other coverage options may be available to you, too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call (800) 318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: (800) 255-4550.

Does this plan provide Minimum Essential Coverage? Yes.

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

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\$40 PCP / \$90 Specialist co-payment, \$4,000 / \$8,000 Deductible Pharmacy: \$20 co-payment / \$70 co-payment / 50% co-insurance; \$500 Deductible (waived for Generics)

Coverage Examples

About these Coverage Examples:

The total Peg would pay is

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>co-payments</u> and <u>co-insurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and foll care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-payment</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	\$4,000 \$90 50% 50%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-payment</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	\$4,000 \$90 50% 50%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist co-payment</u> Hospital (facility) <u>co-insurance</u> Other <u>co-insurance</u> 	٩
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 <i>(including education)</i> Diagnostic tests <i>(blood work)</i> Prescription drugs Durable medical equipment <i>(glucose meter)</i>	g disease	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	\$12,700	Total Example Cost	\$5,600	Total Example Cost	
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$4,000	Deductibles	\$910	Deductibles	;
Co-payments	\$50	Co-payments	\$1,550	Co-payments	
Co-insurance	\$2,980	Co-insurance	\$0	Co-insurance	
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$50	Limits or exclusions	\$20	Limits or exclusions	

The total Joe would pay is

The prescription drug out-of-pocket limit might not be included in the above Coverage Examples.

\$2,480

*Note: This plan has other deductibles for specific services included in the coverage example. See "Are there other deductible for specific services?" row above.

\$7,080

Coverage For: All Plan Type: EPO

low up

\$4,000 \$90 50% 50%

\$2,800

\$1,150 \$570 \$0

\$0

\$1,720

The total Mia would pay is

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

SPANISH

ITALIAN

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator Blue Cross and Blue Shield of Vermont PO Box 186 Montpelier, VT 05601 (802) 371-3394 TDD/TTY: (800) 535-2227 civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

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ご利用は、(800) 247-2583

までお電話ください。

सेवाहरूका लागि, (800) 247-2583

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal. hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 (800) 368-1019 (800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

TAGALOG

VIETNAMESE

Para sa libreng mga serbisyo

Để biết các dich vu hỗ trơ

ngôn ngữ miễn phí, hãy

goi số (800) 247-2583.

sa (800) 247-2583.

ng tulong pangwika, tumawag

For free language-assistance services, call (800) 247-2583.

Para servicios gratuitos de للحصول على خدمات المساعدة asistencia con el idioma, اللغوية المجانية، اتصل على الرقم .(800) 247-2583

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

llame al (800) 247-2583. FRENCH

Per i servizi gratuiti di

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

PORTUGUESE

JAPANESE

NEPALI

Para serviços gratuitos de assistenza linguistica, chiamare assistência linguística, ligue il numero (800) 247-2583. para o (800) 247-2583.

RUSSIAN Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

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