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

**University of Utah Campus Comp Plan**

**Coverage Period:** 07/01/2017 – 06/30/2018

**Coverage for:** Individual and Eligible Family | **Plan Type:** PPO

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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 regence.com or call 1 (800) 262-9712. 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 healthcare.gov/sbc-glossary or call 1 (800) 262-9712 to request a copy.

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### Important Questions

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<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$350 individual / $700 family per contract year.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Doesn’t apply to certain preventive care and services provided by University of Utah Health Care Providers.</td>
<td>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 healthcare.gov/coverage/preventive-care-benefits/.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $200 for each inpatient admission for behavioral health benefits and $300 for each chemical dependency course of treatment not coordinated through the EAP. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,000 individual / $5,000 family per contract year for medical expenses. $2,000 individual / $4,000 family per contract year for prescription drug expenses. $2,000 individual / $4,000 family per contract year for behavioral health and chemical dependency expenses.</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>Premiums, prescription drug out-of-pocket limit, balance-billed 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. See regence.com/PVCU or call 1 (800) 262-9712 for lists of network providers.</td>
<td>This plan uses a provider network. You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a nonparticipating provider, and you might receive a bill from a nonparticipating provider for the difference between the provider’s charge</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.

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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>University Health Care Provider (You pay the least)</th>
<th>What You Will Pay Preferred or Participating Providers (You pay the least)</th>
<th>Nonparticipating Provider (You pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>Spinal manipulations is limited to 20 spinal manipulations / year, subject to the coinsurance specified, after deductible.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>No charge for childhood immunizations from nonparticipating providers.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% coinsurance (not to exceed $150) / prescription</td>
<td>25% coinsurance (not to exceed $150) / prescription</td>
<td>25% coinsurance (not to exceed $150) / prescription</td>
<td>Out-of-pocket limit: $150 per prescription / 30-day fill; $2,000 individual / $4,000 family / year. Limited to a 90-day supply retail and mail order. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill for specialty drugs may be provided at a retail pharmacy; additional fills for specialty drugs must be filled by a specialty pharmacy. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance, unless your provider specifies &quot;dispense as written&quot;</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% coinsurance (not to exceed $150) / prescription</td>
<td>25% coinsurance (not to exceed $150) / prescription</td>
<td>25% coinsurance (not to exceed $150) / prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance (not to exceed $150) / prescription</td>
<td>35% coinsurance (not to exceed $150) / prescription</td>
<td>35% coinsurance (not to exceed $150) / prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (preferred &amp; non-preferred)</td>
<td>Refer to generic, preferred brand and non-preferred brand drugs above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
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<td><strong>Urgent care</strong></td>
<td>Covered the same as the <strong>If you visit a health care provider’s office or clinic</strong> or <strong>If you have a test</strong> above.</td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
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<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Mental/Behavioral health with EAP referral: $25 copay / visit, deductible does not apply. Mental/Behavioral health without EAP referral: 50% coinsurance, deductible does not apply. Substance use disorder with EAP referral: 20% coinsurance, deductible does not apply. Substance use disorder without EAP referral: 50% coinsurance, deductible does not apply.</td>
<td></td>
<td></td>
<td>Limited to 30 outpatient visits / year for mental health services. Limited to 30 inpatient days / year for mental health services. Limited to 2 courses of treatment / lifetime for substance use disorder services. Mental health, behavioral or substance use disorder benefits are administered by Blomquist Hale Consulting Employee Assistance Program and UNI BHN, not Regence BlueCross BlueShield of Utah. Contact Blomquist Hale Consulting EAP or UNI BHN at (801) 587-9319, (801) 262-9619 or (800) 926-9619.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>With EAP referral: 20% coinsurance, deductible does not apply. Without EAP referral: 50% coinsurance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>Adoption coverage is paid at 80% of expenses, limited to $4,000 / qualifying pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. 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>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>Inpatient limited to 30 days / year. Includes physical therapy, occupational therapy and speech therapy services.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td>Outpatient limited to $5,000 / year for occupational therapy; $5,000 / year for physical therapy; $5,000 / year for speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
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<td>Neurodevelopmental therapy</td>
<td>Neurodevelopmental therapy is limited to services for individuals age 18 and under. Includes physical therapy, occupational therapy and speech therapy services.</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>5% coinsurance</td>
<td>25% coinsurance</td>
<td>35% coinsurance</td>
</tr>
</tbody>
</table>

| If your child needs dental or eye care | Children’s eye exam | 5% coinsurance | 25% coinsurance | 35% coinsurance | Limited to 1 routine eye exam / year. |
| Children’s glasses | Not covered | Not covered | Not covered | None |
| Children’s dental check-up | Not covered | Not covered | Not covered | None |

Excluded Services & Other Covered Services:

Exclusion Examples
The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

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, rape of a child, incest or to avert the death of the mother)
- Acupuncture
- Cosmetic surgery, except congenital anomalies
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Vision hardware
- Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied behavioral analysis (ABA) therapy
- Chiropractic care
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Routine eye care

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (800) 262-9712. 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 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 the plan at 1 (800) 262-9712 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Utah Department of Insurance by calling 1 (801) 538-3077 or the toll free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, State Office Building Suite 3110, Salt Lake City, UT 84114-6901; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:
NAVAJO (Dine): Dinek’e shika at’ohwoh ninisingo, kwii’igo holne’ 1 (800) 262-9712.

---To see examples of how this plan might cover costs for a sample medical situation, see the next section.---
**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible $350
- Specialist coinsurance 5%
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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

In this example, Peg would pay:  
**Cost Sharing**  
Deductibles $350  
Copayments $0  
Coinsurance $600  

*What isn’t covered*  
Limits or exclusions $60  
The total Peg would pay is $1,010

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

- The plan’s overall deductible $350
- Specialist coinsurance 5%
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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

In this example, Joe would pay:  
**Cost Sharing**  
Deductibles $350  
Copayments $0  
Coinsurance $1,167  

*What isn’t covered*  
Limits or exclusions $255  
The total Joe would pay is $1,772

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

- The plan’s overall deductible $350
- Specialist coinsurance 5%
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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** $1,925

In this example, Mia would pay:  
**Cost Sharing**  
Deductibles $350  
Copayments $0  
Coinsurance $182  

*What isn’t covered*  
Limits or exclusions $0  
The total Mia would pay is $532

The plan would be responsible for the other costs of these **EXAMPLE** covered services.
DISCRIMINATION IS AGAINST THE LAW

This Notice has Important Information. Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This notice has important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information, and other information about your application or coverage, in your own language at no cost. Call 888-344-6347. (TTY: 711)

HELP IN OTHER LANGUAGES

The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. Regence cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 888-344-6347. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。Regence 遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 888-344-6347 索取。（聽障專線：711）

Vietnamese: Thông báo này có Thông tin Quan trọng. Regence tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 888-344-6347. （聽障專線：711）

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다. Regence은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취셔야 합니다. 귀하는 이 공지 사항에 제시된 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 888-344-6347로 연락하시십시오. （TTY: 711）
Russian: В данном Уведомлении содержится важная информация. Regence несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-344-6347. (TTY: 711)
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Laotian: ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດ. Regence ຮັກສາຄອງຄາບຄົກແບບ ເວລຍອອກ ສັດທີ່ມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ ແລະ ຜັກການຂາຍ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄ和完善ຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກການຂາຍ ແລະ ໂປດມີຄ່າມຄວາມຄິດ. ບໍລິຄໍາຖານນະນັ້ນມີຄ່າມຄວາມຄິດຂອງທັງໝູໜ່ຍ ຜັກgambar: 711)