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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, $0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Preferred Care: Individual $3,000 / Family $6,000.</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, balance-billing charges &amp; 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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of Participating providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$45 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge for laboratory; $45 copay/visit for x-ray</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$45 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription: $10 (retail), $25 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription: $40 (retail), $100 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription: $60 (retail), $150 (mail order)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>25% copay up to $150 maximum/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$175 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$200 copay/visit</td>
<td>$200 copay/visit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No coverage for non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay/visit</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$350 copay/stay</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health,</td>
<td>Outpatient services</td>
<td>Office &amp; other</td>
<td>None</td>
</tr>
<tr>
<td>or substance abuse services</td>
<td></td>
<td>outpatient services:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$45 copay/visit</td>
<td>Non-urgent use.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$350 copay/stay</td>
<td>Non-urgent use.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$45 copay/pregnancy</td>
<td>Maternity care may include tests and services</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$350 copay/stay</td>
<td>described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Home health care</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>other special health needs</td>
<td>Rehabilitation services</td>
<td>$45 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$45 copay/visit</td>
<td>Limited to treatment of Autism.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$350 copay/stay</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$350 copay/stay</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>1 routine eye exam/12 months.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |
|---|---|---|
| • Acupuncture | • Glasses (Child) | • Private-duty nursing |
| • Bariatric surgery | • Hearing aids | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss care - Except for required preventive services. |
| • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. | |
| • Routine eye care (Adult) | | |

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care - 20 visits/plan year.</td>
</tr>
<tr>
<td>• Infertility treatment - Limited to the diagnosis &amp; treatment of underlying medical condition.</td>
</tr>
</tbody>
</table>

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:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
• Additionally, a consumer assistance program can help you file your appeal. Contact information is at:
  

**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 Minimum Value Standard?** 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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To see examples of how this plan might cover costs for a sample medical situation, see the next section.-------------------
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: $0
- Specialist Copayment: $45
- Hospital (facility) Copayment: $350
- Other Copayment: $0

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:
- Deductibles: $0
- Copayments: $500
- Coinsurance: $0

**What isn't covered**: Limits or exclusions $60

**The total Peg would pay is**: $560

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

- The plan’s overall deductible: $0
- Specialist Copayment: $45
- Hospital (facility) Copayment: $350
- Other Copayment: $0

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:
- Deductibles: $0
- Copayments: $1,500
- Coinsurance: $0

**What isn't covered**: Limits or exclusions $20

**The total Joe would pay is**: $1,520

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

- The plan’s overall deductible: $0
- Specialist Copayment: $45
- Hospital (facility) Copayment: $350
- Other Copayment: $0

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**: $1,900

In this example, Mia would pay:
- Deductibles: $0
- Copayments: $400
- Coinsurance: $0

**What isn't covered**: Limits or exclusions $0

**The total Mia would pay is**: $400

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

**Language Assistance:**

For language assistance in your language call 1-888-982-3862 at no cost.

- **Albanian** - Për asistëncë në gjuhën shqipe telefononi falas në 1-888-982-3862.
- **Amharic** - ያContaining ለመሸከት ያስታወቂለን ያለወ ያለሁ እንደ የተለቀጠ ያለ ለመሸከት ያለሁ እንደ የ1-888-982-3862 ከመሸከት ከቀነስ።
- **Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.
- **Armenian** - Ներքին գործունցերով ապահովումն է (հայերեն) գնով 1-888-982-3862 զանգի.</p>
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- **Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
- **Bengali-Bangala** - লেলাশে প্রশ্নের জন্য নম্বর 1-888-982-3862 খুব সহজে.
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- **Burmese** - အသုံးပြုသော အမျိုးအစား ဖြင့် 1-888-982-3862 ကြည့်ပါ။
- **Catalan** - Per rebre assistència en (català), truqui al número gratuit 1-888-982-3862.
- **Chamorro** - Para ayuda gi fино' (Chamoru), ågang 1-888-982-3862 sin ġastu.
- **Cherokee** - ᎠᏍᎩᎩᏱ ᓭ_hsȟą dóh ᎣCompraও ᭗Ꮻ (CWY) ᮴工商局 ᏭᎫ�펐 1-888-982-3862 Ꮰلاقة Ꭼ高潮 Ꮿ Haskell ᎯᎣᏰθ.
- **Chinese** - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
- **Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuu lakkokofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
- **Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- **French** - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- **German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- **Gujarati** - ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ☑️ ❌

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asusu na Igbo kpọọ 1-888-982-3862 na akwughị ọgwọ ọ bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Ilocano - Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-888-982-3862.

Italian - Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - Be’m ké gbo-kpá-kpá dyé pidyi qé Baso-woqoq’weé, qá 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 تماس بگیرید.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kuwa-Bassa - Ñan bōk jipañ Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnän.

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Navajo - T’áá shi shizaad k’ehjí bee shiká a’doowol ninízingo Diné k’ehjí kojjí’ t’áá jiik’e hólne’ 1-888-982-3862

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