### Important Questions | Answers | Why This Matters:
--- | --- | ---
**What is the overall deductible?** | For each Plan Year, In-Network: Individual $300 / Family $900. Out-of-Network: Individual $800 / Family $2,400. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**Are there services covered before you meet your deductible?** | Yes. Emergency care; plus in-office visits & preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | In-Network: Individual $1,200 / Family $3,600. Out-of-Network: Individual $2,400 / Family $7,200. Prescription drugs: Individual $2,000 / Family $6,000. | 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?** | Premiums, balance-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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. See [www.aetna.com/docfind](http://www.aetna.com/docfind) or call 1-888-302-8742 for a list of in-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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least): $30 copay/visit, deductible doesn't apply</td>
<td>Out-of-Network Provider (You will pay the most): 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Deductible doesn't apply: $30 copay/visit for laboratory; $50 copay/visit for x-ray</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>10% coinsurance up to maximum/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)</td>
<td>10% coinsurance up to maximum/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)</td>
</tr>
<tr>
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<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>drug coverage</strong> is available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Deductible doesn't apply: 30% coinsurance up to $100 maximum/prescription (retail), 20% coinsurance up to $100 maximum/prescription (mail order)</td>
<td>Deductible doesn't apply: 30% coinsurance up to $100 maximum/prescription (retail), 20% coinsurance up to $100 maximum/prescription (mail order)</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>10% coinsurance with minimum &amp; maximum/prescription, deductible doesn't apply: $15 minimum &amp; $100 maximum (retail), $30 minimum &amp; $200 maximum (mail order)</td>
<td>10% coinsurance with minimum &amp; maximum/prescription, deductible doesn't apply: $15 minimum &amp; $100 maximum (retail), $30 minimum &amp; $200 maximum (mail order)</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Not covered</td>
<td>Specialty drugs can be dispensed at CVS Pharmacies, CVS Specialty Mail Service, pharmacies at the Hospital of University of Pennsylvania, Penn Presbyterian Medical Center, Pennsylvania Hospital and Penn Medicine Radnor.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>40% coinsurance for out-of-network non-emergency transport.</td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-urgent care.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room) 20% coinsurance 20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care. None</td>
</tr>
<tr>
<td>出of-network care</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 100% deductible waived</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services 20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits No charge</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care 20% coinsurance</td>
<td>40% coinsurance</td>
<td>240 visits/plan year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. 60 visits/plan year for Physical &amp; Occupational Therapy combined. 60 visits/plan year for Speech Therapy.</td>
</tr>
<tr>
<td>Rehabilitation services $40 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td>Limited to treatment of Autism.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services $40 copay/visit, deductible doesn't apply</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care 20% coinsurance</td>
<td>40% coinsurance</td>
<td>180 days/plan year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment 20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hospice services</td>
<td></td>
<td></td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>40% coinsurance</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
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Bariatric surgery
- Chiropractic care - 60 visits/plan year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.
- Private-duty nursing

### 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 1-888-302-8742.
- 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: [https://www.dol.gov/agencies/ebsa](https://www.dol.gov/agencies/ebsa)
- 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 1-888-302-8742.
• 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 https://www.dol.gov/agencies/ebsa
• 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: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 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.------------------
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: $300
- Specialist copayment: $50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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 | $300 |
| Copayments | $200 |
| Coinsurance | $2,200 |

**What isn't covered** | 
| Limits or exclusions | $60 |
| The total Peg would pay is | $2,760 |

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

- The plan's overall deductible: $300
- Specialist copayment: $50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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 | $0 |
| Copayments | $400 |
| Coinsurance | $600 |

**What isn't covered** | 
| Limits or exclusions | $20 |
| The total Joe would pay is | $1,020 |

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

- The plan's overall deductible: $300
- Specialist copayment: $50
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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:**
**Cost Sharing** | 
| Deductibles | $300 |
| Copayments | $400 |
| Coinsurance | $60 |

**What isn't covered** | 
| Limits or exclusions | $0 |
| The total Mia would pay is | $760 |

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: 1-888-302-8742.

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 1-888-302-8742.

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: CRCordinator@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 1-888-302-8742 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-302-8742.
Amharic - የመስፋ木耳 ያለመስፋ木耳 ብቅርቱ 1-888-302-8742 ያስጠbservice
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-302-8742
Armenian - Լեզվի գործարարության աջակցության (հայերեն) զանգի 1-888-302-8742 զանգի զանգ
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-302-8742 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-302-8742 ku busa
Bengali-Bangala - 1-888-302-8742-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-302-8742 nga walay bayad.
Burmese - 1-888-302-8742
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-302-8742.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-302-8742 sin gåstu.
Cherokee - 1-888-302-8742
Chinese - 欲取得繁體中文語言協助，請撥打 1-888-302-8742，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi i paya hinla 1-888-302-8742.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-302-8742 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-302-8742.
French - Pour une assistance linguistique en français appeler le 1-888-302-8742 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-302-8742 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-302-8742 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-302-8742 χωρίς χρέωση.
Gujarati - 1-888-302-8742 पर कल करें।

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-302-8742 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asu su na Igbo kpọ 1-888-302-8742 na akwụghị ọgwọ ọ bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-302-8742 nga awan ti bayadanyo.

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-302-8742 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-302-8742.

Japanese - 日本語で援助をご希望の方は、1-888-302-8742 まで無料でお電話ください。

Karen - ကြည်းစာအုပ် အသိပေးပါကလား၊ ကြည်းစာအုပ် 1-888-302-8742

Kurdish - 1-888-302-8742

Laotian - 1-888-302-8742

Marathi - 1-888-302-8742

Marshallese - 1-888-302-8742

Micronesian-Pohnpeian - Ohng palien sawas en sound kawewe ni omw lokaia Ponape koahl 1-888-302-8742 ni sohte isais.

Mon-Khmer, Cambodian - 1-888-302-8742

Navajo - T'áá shi shizaad k'ehjí bee shíká a' doowol ninizingo Diné k'ehjí koji' t'áá jík'e hólne' 1-888-302-8742

Nepali - 1-888-302-8742

Nilotic-Dinka - Tën kuöny ë thok ë Thuongjän ciol 1-888-302-8742 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-302-8742 kostnadsfritt.

Panjabi - 1-888-302-8742


Persian - براي راهنمایي به زبان فارسي با شماره 1-888-302-8742 بیون همیشه اتی تماس بگیرید.

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-302-8742.
Para obter assistência linguística em português ligue para o 1-888-302-8742 gratuitamente.

Pentru asistență lingvistică în româneste telefonați la numărul gratuit 1-888-302-8742.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-302-8742.

Mo fesoasoani tau gagana le Gagana Samoa val'a le 1-888-302-8742 e aunoa ma se totoni.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-302-8742.

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-302-8742.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-302-8742. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-302-8742 bila malipo.

1-888-302-8742

Para sa tulong sa wika na Tagalog, tawagan ang 1-888-302-8742 nang walang bayad.

1-888-302-8742 Բռանյական համար

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทรศัพท์ 1-888-302-8742 หรือไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-302-8742 ‘o ‘iikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-302-8742 nge esapw kamé ngonuk.

(Dil) çağrı dil yardımı için. Hiçbir ücret ödededen 1-888-302-8742.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-302-8742.

1-888-302-8742

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-888-302-8742.

Fẹrẹ ọfẹrẹ rẹtọ ẹni Adìsi Rẹtọ 1-888-302-8742. (Bàlàgà)

Fún iránlọwọ nipa èdè (Yorùbá) pe 1-888-302-8742 lái san owó kankan rará.