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.aetnastudenthealth.com/ or by calling 1-800-878-1945. 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 1-800-878-1945 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, In-Network: Individual $200. Out-of-Network: Individual $250.</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. Emergency care &amp; prescription drugs; plus in-network office visits &amp; preventive care are covered before you meet your deductible.</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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>In-Network: Individual $6,350 / Family $12,700. Out-Of-Network: Individual NONE / Family NONE.</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, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</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 1-800-878-1945 for a list of in-network 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>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.

<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></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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance, 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>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail), $45 (mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail), $120 (mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $40 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn't apply: $75 (retail), $225 (mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $75 (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [https://www.aetna.com/individuals-families/pharmacy.html](https://www.aetna.com/individuals-families/pharmacy.html)
<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>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 copay/visit, deductible doesn't apply</td>
<td>$250 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>20% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 20% coinsurance, deductible doesn't apply; other outpatient services: 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$35 copay/visit, deductible doesn't apply</td>
<td>$35 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$35 copay/visit, deductible doesn't apply</td>
<td>$35 copay/visit, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</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>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</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, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</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)
- Hearing aids
- Long-term care
- 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
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/plan year.
Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia State Corporation Commission, Bureau of Insurance, 800-552-7945 (Virginia only), 804-371-9741, http://www.scc.virginia.gov/boi/index.aspx.

• For more information on your rights to continue coverage, contact the plan at 1-800-878-1945.

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 1-800-878-1945.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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: $200
- Specialist coinsurance: 20%
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $60

The total Peg would pay is **$2,800**

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

- The plan's overall deductible: $200
- Specialist coinsurance: 20%
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $20

The total Joe would pay is **$1,720**

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

- The plan's overall deductible: $200
- Specialist coinsurance: 20%
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**: $0

The total Mia would pay is **$600**

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 1-800-878-1945.

**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.**
For language assistance in your language call 1-800-878-1945 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-878-1945.
Amharic - እስካርነት እ💁�� እ መናየር ብ 1-800-878-1945 እኔ ከፋወ ከ።
Arabic - للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني 1-800-878-1945.
Armenian - Լեզվի գործազորություն (հայերեն) զանգ 1-800-878-1945 անդամ գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-878-1945 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-878-1945 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-878-1945-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-878-1945 nga walay bayad.
Burmese - ငွေပစ္စည်းသုံးစွဲချက် မှ အောက်ပါ အတွက် 1-800-878-1945
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-878-1945.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-878-1945 sin gástu.
Cherokee - ḞoĎųʔ Sǝʉʔ.Ko.1 .IhooSɬo.ɬ Θ.ɬ'T (GWV) Θ.WoʔIς 1-800-878-1945 Ω.Θ.Ł ȺGǒ.1 JEG.P.I H FR.Ò.
Chinese - 欲取得繁體中文語言協助，請撥打 1-800-878-1945，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-878-1945.
Cushite - Gargaarsa afan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-878-1945 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-878-1945.
French - Pour une assistance linguistique en français appeler le 1-800-878-1945 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-878-1945 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-878-1945 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-878-1945 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લ સ સ ય મકરવું મા ટે કોઈ પણ અર્થ વચ્ચે 1-800-878-1945 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-878-1945. Kāki ‘ole ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-878-1945 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka asusu na Igbo kpoo 1-800-878-1945 na akwughī ugwo o bula

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-878-1945 nga awan ti bayadanyo.

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-878-1945 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-878-1945.

Japanese - 日本語で援助をご希望の方は、1-800-878-1945まで無料でお電話ください。

Karen - 1-800-878-1945

Korean - 한글로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-878-1945번으로 전화해 주십시오.

Kru-Bassa - Be’m ké gbo-kpà-kpá dyé pidiy dé Basoó-wuquîn wëc, qa 1-800-878-1945

Kurdish - 1-800-878-1945

Laotian - 1-800-878-1945

Marathi - कोणत्याही शुल्काशीवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-878-1945 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-878-1945 ilo ejjelok wônān.

Micronesian-Pohnpeyan - Ohng palien sawas en souw kawewe ni omw lokaia Ponape koahl 1-800-878-1945 ni sohte isais.

Mon-Khmer, Cambodian - 1-800-878-1945

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínìzingo Diné k'ehjí kojí t'áá jíí jík'e hólne' 1-800-878-1945

Nepali - (नेपाली) मा निशुल्क भाषा सहायता पाउनका लागि 1-800-878-1945 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kuony ë thok ë Thuonjâŋ cöl 1-800-878-1945 kecîn ayôc.

Norwegian - For språkassistanse på norsk, ring 1-800-878-1945 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਹਿੰਦੀ ਭਾਸ਼ਾ ਮਧੋਣਾ ਲਾਗੀ, 1-800-878-1945 ਵੇਲ ਭਰੁਆ ਵਰਤੋਂ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-878-1945 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-878-1945 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-878-1945.
Para obter assistência linguística em português ligue para o 1-800-878-1945 gratuitamente.

Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-800-878-1945.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-878-1945.

Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-800-878-1945 e aunoa ma se tootogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-878-1945.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-878-1945.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-878-1945. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-878-1945 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-878-1945 nang walang bayad.

మార్గం తెలుగు దీనికి మాత్రమే ఇది సాంస్కృతిక సేవలు 1-800-878-1945 మేరు సంఖ్యగా ఉంటాయి. (ఓమాగా)

สำหรับความช่วยเหลือทางภาษาเป็น ภาษาไทย โทร 1-800-878-1945 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-878-1945 ‘o ‘ikai hā òtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-878-1945 nge esapw kamé ngonuk.

(Dil) çağrısı dil yardım için. Hiçbir ücret ödedenen 1-800-878-1945.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-878-1945.

Підайте нам свідчення, зв'язок з місцем, щоб задокументувати, які послуги ми надаємо 1-800-878-1945.

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số’1-800-878-1945.

Fün iranlöwọ nipa èdè (Yorùbá) pe 1-800-878-1945 lái san owó kankan rará.