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, http://www.aetnastudenthealth.com or by calling 1-877-375-7905. 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 1-877-375-7905 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For each Plan Year, In-Network: Individual: $400. Out-of-Network: Individual: $800.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-Network care for preventive care, In-Network care for family planning services - female contraceptives, In-Network care for pediatric dental services, In- and Out-of-Network Care for prescription drugs, In- and Out-of-Network Care for pediatric vision services, and In- and Out-of-Network Care for immunizations for children under 5 years of age 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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></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><strong>What is not included in the out-of-pocket limit?</strong></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><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-877-375-7905 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 (a balance bill). 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><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Common Medical Event

<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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance after $20 copay/visit</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% coinsurance after $20 copay/visit</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance, except no charge for immunizations up to age 5</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs (includes specialty drugs)</td>
<td>Copay/prescription, deductible doesn't apply: $15 for 30 day supply (retail), $30 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $15 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail &amp; mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Step therapy and formulary exclusions may apply.</td>
</tr>
<tr>
<td>Preferred brand drugs (includes specialty drugs)</td>
<td>Copay/prescription, deductible doesn't apply: $35 for 30 day supply (retail), $70 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $35 (retail)</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs (includes specialty drugs)</td>
<td>Copay/prescription, deductible doesn't apply: $50 for 30 day supply (retail), $100 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $50 (retail)</td>
<td></td>
</tr>
</tbody>
</table>

*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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance after $100 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance after $100 copay/visit</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance after $200 copay/stay</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>In-Network Provider (You will pay the least): Office: 20% coinsurance after $20 copay/visit; other outpatient services: 20% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care for intensive outpatient program (IOP) – mental disorder and substance abuse diagnoses, outpatient detoxification, and partial hospitalization treatment – mental disorder and substance abuse diagnoses</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance after $200 copay/stay</td>
<td>None</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 help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>30% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>30% coinsurance</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 - Except in lieu of anesthesia
  - Bariatric surgery
  - Cosmetic surgery
  - Dental care (Adult)
  - Long-term care
  - Routine eye care (Adult)
  - 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.)
  - Chiropractic care
  - Hearing aids - 1 hearing aid per ear/plan year.
  - Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
  - Non-emergency care when traveling outside the U.S.
  - 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: Missouri Division of Insurance, (573) 751-4126, http://insurance.mo.gov/consumers.

- For more information on your rights to continue coverage, contact the plan at 1-877-375-7905.
- State Consumer Assistance Program, if other than state insurance department contact Missouri Division of Insurance, P.O. Box 690, Jefferson City, MO 65102, (800) 726-7390, https://insurance.mo.gov/consumers/, consumeraffairs@insurance.mo.gov

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 1-877-375-7905.
- Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Division of Insurance, P.O. Box 690, Jefferson City, MO 65102, (800) 726-7390, https://insurance.mo.gov/consumers/, consumeraffairs@insurance.mo.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 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$400</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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** | $400 |
- **Copayments** | $40 |
- **Coinsurance** | $2,400 |

**What isn’t covered**
- **Limits or exclusions** | $60 |

**The total Peg would pay is** | $2,900 |

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** | $100 |
- **Copayments** | $1,300 |
- **Coinsurance** | $200 |

**What isn’t covered**
- **Limits or exclusions** | $20 |

**The total Joe would pay is** | $1,620 |

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** | $400 |
- **Copayments** | $0 |
- **Coinsurance** | $300 |

**What isn’t covered**
- **Limits or exclusions** | $0 |

**The total Mia would pay is** | $700 |

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 1-877-375-7905.

**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.**
TTY: 711

Language Assistance:

For language assistance in your language call 1-877-375-7905 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-375-7905.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-375-7905.
Armenian - Հետաձգմանի համար կարող եք կապվել 1-877-375-7905-ի սեփական գնով
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-375-7905 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-877-375-7905 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-375-7905-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-375-7905 nga walay bayad.
Burmese - 1-877-375-7905
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-375-7905.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-375-7905 sin gåstu.
Cherokee - ᎠᏍᎩᏐᏏᏂhawks ᏅᏣᏰᏗᏔᏔ ᏗᎾᎵᏜ Eyl (GWA) ᏅᏯᏯTyped 1-877-375-7905 ᏇᏣᏗ ᏤᏝᏗᎵᏗ ᏝᏗᏔ unlink ᏛᏘᏗᏔ 1-877-375-7905
Chinese - 欲取得繁體中文語言協助，請撥打 1-877-375-7905，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi i paya hinla 1-877-375-7905.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-375-7905 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-375-7905.
French - Pour une assistance linguistique en français appeler le 1-877-375-7905 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-375-7905 gratis.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-375-7905 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ પછી વગર 1-877-375-7905 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-375-7905 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-375-7905.

Ibo - Maka enyemaka asusụ na Igbo kpọọ 1-877-375-7905 na akwụkwọ ugwọ ọ buịa

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-375-7905 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-375-7905.

Japanese - 日本語で援助をご希望の方は、1-877-375-7905まで無料でお電話ください。

Karen -  v>w>frRp>Rw>fuwdRusd.f't'D>f usd.f ud; 1-877-375-7905 v>wtd.f'D;w>fv>mfbl.fv>mfphRb.

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-375-7905 번으로 전화해 주십시오.

Kru-Bassa - Bɛ́ m̀ ké gbo kpá kpá dyé pidy dié Bäsö-wúquün wée, då 1-877-375-7905

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-877-375-7905 به خورایی پیامبندی بکان.

Laotian - ðu ʻu vang ʻo vung ʻo vung ʻo voeted ʻo ving ʻo ving ʻo ving ʻo ving ʻo ving ʻo ving ʻo ving ʻo ving 1-877-375-7905 diye ðe 'rae ʻo gay.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-375-7905 क्रमांकावरकोणत्याहीख्यातीशिवाय कॉल करा.

Marshallese - Ŝan bōk jipañ ilo Kajin Majol, kalloc 1-877-375-7905 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-375-7905 ni sohte isais.

Mon-Khmer, Cambodian - កប្រជាជនកម្ពុជា នីយានិច អេស្ប៉ាប់លាក់កណ្តាល 1-877-375-7905 ស្នាដៃយើងជីយើង។

Navajo - T'áá shi shizaad kehji bee shiká a'doowol nínìzingo Diné kehji koji t'áá jílk'e hólne' 1-877-375-7905

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-877-375-7905 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuconn yé thok é Thuoŋjāŋ cół 1-877-375-7905 kecín ayócc.

Norwegian - For språkassistanse på norsk, ring 1-877-375-7905 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਲੋਕ ਲੰਘਾਦੀ ਮਾਦਰੀਟਿੱਂ ਲਾਗੀ, 1-877-375-7905 ਤੋ ਮੁੱਢ ਵਾਸ ਵਦੇ।
