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

Coverage Period: 05/01/2019-07/31/2020

NOVA SOUTHEASTERN UNIVERSITY: Open Choice®

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 1-855-821-9720. 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 1-855-821-9720 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 $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>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network 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 $5,750. Out-of-Network: Individual NONE.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</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 1-855-821-9720 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>Yes, services within 25 miles of health center for certain conditions. Refer to policy for details.</td>
<td>*Referral requirement do not apply to satellite campuses. 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><strong>If you visit a healthcare provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>30% coinsurance after $30 copay/visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>30% coinsurance after $30 copay/visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance, except deductible doesn’t apply to well child &amp; immunizations up to age 17</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</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></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $15 (retail)</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: $50 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $75 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $75 (retail)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $45 (retail)</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail)</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>30% coinsurance after $300 copay/visit</td>
<td>30% coinsurance after $300 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>
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<tr>
<td>-----------------------------------------------------------</td>
<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></td>
<td></td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Urgent care</td>
<td>30% coinsurance after $150 copay/visit</td>
<td>50% coinsurance after $150 copay/visit</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance, deductible doesn't apply</td>
<td>50% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance, deductible doesn't apply</td>
<td>50% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Rehabilitation services</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Habilitation services</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Hospice services</td>
<td>30% 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>50% coinsurance, deductible doesn't apply</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>
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<td>----------------------</td>
<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>Children's glasses</td>
<td>No charge</td>
<td>50% coinsurance, deductible doesn't apply</td>
<td>1 pair of glasses or lenses/plan year.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>None</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.**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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.)**

- Acupuncture
- Chiropractic care
- Hearing aids – 1 hearing aid per ear/24 months.
- Non-emergency care when traveling outside the U.S.

**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 Florida Department of Financial Services, Division of Consumer Services, 877-693-5236, 850-413-3089 (Out of State), 800-640-0886 (TDD), [http://www.myfloridacfo.com/Division/Consumers/](http://www.myfloridacfo.com/Division/Consumers/)

- For more information on your rights to continue coverage, contact the plan at 1-855-821-9720.

**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 1-855-821-9720.
- Florida Department of Financial Services, Division of Consumer Services, 877-693-5236, 850-413-3089 (Out of State), 800-640-0886 (TDD), [http://www.myfloridacfo.com/Division/Consumers/](http://www.myfloridacfo.com/Division/Consumers/)
**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</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$400</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist coinsurance</td>
<td>30%</td>
<td>Specialist coinsurance</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>30%</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>30%</td>
<td>Other coinsurance</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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,700</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $60

The total Peg would pay is $4,200

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></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $20

The total Joe would pay is $2,120

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></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions $0

The total Mia would pay is $900

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 1-855-821-9720.

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 1-855-821-9720 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-821-9720.

Amharic - እስተዳ箉箉 አማርኛ ሳምን ከ 1-855-821-9720 ያስተዳ箉箉 ያደርጉ.

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-821-9720.

Armenian - Լեզվի ցուցաբերած աջակցությ ドル (հայերեն) զանգի 1-855-821-9720 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-821-9720 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-821-9720 ku busa

Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনামূল্যে 1-855-821-9720-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-821-9720 nga walay bayad.

Burmese - မြန်မာဘာသာ အသုံးပြုသူနှင့် အတူနှစ်သက် 1-855-821-9720 မြောက်စွာ

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-855-821-9720.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-855-821-9720 sin gåstu.

Cherokee - ᎠᎣᏫᏦᏔᏱ ᎣᏰᎷ ᎨᏫᏣᏜᏣ ᎨᏫᏣᏜᏣ ᎨᏫᏦᏔᏱ (GWA) ᎨᏫᏦᏔᏱ 1-855-821-9720 ᎣᏣᏫᎴᏫᏣ ᏣᏰᎷ ᏫᏨᏦ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-855-821-9720，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-855-821-9720.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa billbila 1-855-821-9720 irratti billasaan billbila.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-821-9720.

French - Pour une assistance linguistique en français appeler le 1-855-821-9720 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyól Ayisyen, rele nimewo 1-855-821-9720 gratis.


Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-821-9720 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં લાભામાં સહાય માટે કોઈ પણ અર્થ વગર 1-855-821-9720 પર કોલ કરો.
Para obter assistência linguística em português ligue para o 1-855-821-9720 gratuitamente.

Пентру асистенță lingvistică în românăște telefonăți la numărul gratuit 1-855-821-9720

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-821-9720.

Mo fesoasoani tau gagana le Gagana Samoa val'a'au le 1-855-821-9720 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-821-9720.

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-821-9720.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-821-9720. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-821-9720 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-821-9720 nang walang bayad.

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