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/](https://www.aetnastudenthealth.com/) or by calling 1-800-841-5374. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-841-5374 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 / Family $0. Out-of-Network: Individual $1,500 / Family $0.</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. Prescription drugs &amp; emergency care; 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><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 $1,500 / Family $3,000. Out-of-Network: Individual $4,000 / $8,000.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services.</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 1-800-841-5374 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><strong>Do you need a referral to see a specialist?</strong></td>
<td>Yes, refer to policy.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission 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>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>$35 <strong>copay/visit</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 <strong>copay/visit</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$35 <strong>copay/visit</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 <strong>copay/visit</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail), $60 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn’t apply: $20 (retail)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (retail), $150 for 31-90 day supply (retail &amp; mail order)</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: $50 (retail), $150 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn’t apply: $50 (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><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 <strong>copay/visit</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></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 room care</td>
<td>In-Network Provider: $100 copay/visit</td>
<td>Out-of-Network Provider: $100 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 copay/visit</td>
<td>30% coinsurance after $100 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $10 copay/visit; other outpatient services: no charge</td>
<td>Office &amp; other outpatient services: 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$100 copay/stay</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$100 copay/stay</td>
<td>30% coinsurance after $100 copay/stay</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$35 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$35 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$100 copay/stay</td>
<td>30% coinsurance after $100 copay/stay</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>30% 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>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| • Acupuncture  
• Bariatric surgery  
• Cosmetic surgery  |
| • Dental care (Adult)  
• 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.)

| • 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  
• Routine eye care (Adult) - 1 routine eye exam/plan year. Up to $125/plan year for eyeglasses or contact lenses |

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: Pennsylvania Department of Insurance, Bureau of Consumer Services, Phone: 877-881-6388, TTY/TDD: 717-783-3898, [http://www.insurance.pa.gov/Consumers](http://www.insurance.pa.gov/Consumers).
- For more information on your rights to continue coverage, contact the plan at 1-800-841-5374.

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 1-800-841-5374.

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**: $400
- **Specialist copayment**: $35
- **Hospital (facility) copayment**: $100
- **Other coinsurance**: 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**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $2,260

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

- **The plan’s overall deductible**: $400
- **Specialist copayment**: $35
- **Hospital (facility) copayment**: $100
- **Other coinsurance**: 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**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is**: $2,520

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

- **The plan’s overall deductible**: $400
- **Specialist copayment**: $35
- **Hospital (facility) copayment**: $100
- **Other coinsurance**: 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**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $2,100

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 1-800-841-5374.

**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 1-800-841-5374 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-841-5374.
Amharic - እስከንፋል ከማ የለምያ መ 1-800-841-5374 መልቅ ይቻል።
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-841-5374.
Armenian - Անվտանգ նպատակով պաշտպանության (առաջընթաց) գրանցում 1-800-841-5374 առաջադրում գրանցում:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-841-5374 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-841-5374 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-841-5374-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-841-5374 nga walay bayad.
Burmese - မြန်မာစိန် အစိုးရ အခြေခံနိုင်ငံရေး 1-800-841-5374 အပြောင်းအလဲမှာ
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-841-5374.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-841-5374 sin gástu.
Cherokee - Ooł tłįh Soh-tał. Ooł tłįh Soh-tał (GWV) Ow Wö’Is 1-800-841-5374 O’ṭ Ł AGoł Ł JEGP Ł TtRŁ.
Chinese - 欲取得繁體中文語言協助，請撥打1-800-841-5374，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-841-5374.
Cushite - Gargaarsa afaan Oromiffa hii kuq argachuuuf lakkokkofs bibbilaa 1-800-841-5374 irratti bilisaan bibbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-841-5374.
French - Pour une assistance linguistique en français appeler le 1-800-841-5374 sans frais.
French Creole - Pou jven asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-841-5374 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-841-5374 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-841-5374 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લાખામાં સહાય માટે કોઈ પણ અર્થ વગર 1-800-841-5374 પર કોલ કરો.
Hawaiian - No ke ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-841-5374. Kāki ʻole ia kēia ʻōlelo nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-841-5374 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-841-5374.

Ibo - Maka enyemaka asusu na Igbo kpọ 1-800-841-5374 na akwughị Ngwo ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-841-5374 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, puó chiamare gratuitamente 1-800-841-5374.

Japanese - 日本語で援助をご希望の方は、1-800-841-5374まで無料でお電話ください。

Karen - 1-800-841-5374

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-841-5374 번으로 전화해 주십시오.

Kru-Bassa - Bɛ’m ké gbo-kpá-kpá dyé pidyi qé Basso-wuquün wee, qa 1-800-841-5374

Kurdish - 1-800-841-5374

Laotian - 1-800-841-5374

Marathi - 1-800-841-5374

Marshallese - Nan bōk jipañ ilo Kajin Majol, kallok 1-800-841-5374 ilo ejjelok wonān.

Micronesian-Pohnpeyan - Ohng palien sawas en sou n kawe we ni omw lokaia Ponape koahl 1-800-841-5374 ni sohte isais.

Mon-Khmer, Cambodian - 1-800-841-5374

Navajo - T'áá shi shizaad ke'hjí bee shiká a'dowool nínízingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-800-841-5374

Nepali - (Nepal) मा नि:ङ्क्षक भाषा सहायता पाउनका लागि 1-800-841-5374 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tén kuony ë thok ë Thuŋjŋañ cal 1-800-841-5374 kecin ayoc.

Norwegian - For språkassistanse på norsk, ring 1-800-841-5374 kostnadsfritt.

Panjabi - ਫ੍ਰੇਂਚ ਇੰਗਰੀ ਭਾਸ਼ਾ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਪਾਉਣ ਲਾਗੀ 1-800-841-5374 ਵੀ ਸੂਚੀਬੱਧ ਬਲਕਲਵੇ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-841-5374 aa. Es Aaruf koschtet nix.

Persian - براي راهنمايی به زبان فارسي با شماره 1-800-841-5374 بدون هچيچ هزینه اي تماس بگيريد. انگليسي

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-841-5374.
Para obter assistência linguística em português ligue para o 1-800-841-5374 gratuitamente.

Pentru asistență lingvistică în română, telefonați la numărul gratuit 1-800-841-5374.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-841-5374.

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