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

**STATE OF IL**

**LOCAL CARE HEALTH PLAN (LCHP): Aetna**

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.aetnasateofillinois.com/health-plans](https://www.aetnasateofillinois.com/health-plans) or by calling 1-855-856-0038. 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 1-855-856-0038 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>$1,000 per enrollee.</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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network preventive care is 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. You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $350 per in-network hospital admission; $600 per out-of-network hospital admission; $400 per emergency room visit; $250 for organ and tissue transplants; $175 for prescription drugs.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. This 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 the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: Individual $2,000 / Family $4,000. Out-Of-Network: Individual $6,000 / Family $12,000.</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. Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services &amp; health care this plan doesn’t cover.</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>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 1-800-370-4526 for a list of In-Network providers.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td></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><em>If you visit a health care provider’s office or clinic</em></td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><em>If you have a test</em></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><em>If you need drugs to treat your illness or condition</em></td>
<td>Tier I</td>
<td>30 day supply: $15.00; 90 day supply: $30.00</td>
<td>Maintenance Choice (90 Day Supply)** $15</td>
</tr>
<tr>
<td></td>
<td>Tier II</td>
<td>30 day supply: $30.00; 90 day supply: $60.00</td>
<td>Maintenance Choice (90 Day Supply)** $30</td>
</tr>
<tr>
<td></td>
<td>Tier III</td>
<td>30 day supply: $60.00; 90 day supply: $120.00</td>
<td>Maintenance Choice (90 Day Supply)** $60</td>
</tr>
<tr>
<td><em>If you have outpatient surgery</em></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><em>If you need immediate medical attention</em></td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance, 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</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 have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance, Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>50% 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>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</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>
</tbody>
</table>

Mental Health & Substance Abuse benefits not provided by Aetna. Coverage for these services is administered by Magellan Health. More information is available at [www.magellanascend.com](http://www.magellanascend.com), or contact Magellan at 1-800-513-2611. Pre-authorization may be required. If pre-authorization is not obtained, benefits may be reduced or not covered.

Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization may be required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.

Custodial care not covered. Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.

Pre-authorization required for out-of-network care. If pre-authorization is not obtained, benefits may be reduced or not covered.
### 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>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</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.):**

- Acupuncture
- Cosmetic surgery
- Custodial care
- Dental care
- Long-term care
- Private-duty nursing
- Routine eye 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
- Chiropractic care - 30 visits/plan year.
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment.

### 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:


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](http://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 by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038; or
• Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.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 Standard? 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: $1,000
- 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>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,348</td>
</tr>
</tbody>
</table>

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

The total Peg would pay is **$3,408**

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: 1-855-856-0038.

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

- The plan’s overall deductible: $1,000
- 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>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,276</td>
</tr>
</tbody>
</table>

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

The total Joe would pay is **$2,296**

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

- The plan’s overall deductible: $1,000
- 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>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$180</td>
</tr>
</tbody>
</table>

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

The total Mia would pay is **$1,180**

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 1-855-856-0038.

**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 1-855-856-0038 at no cost.

- **Albanian** - Per asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.
- **Amharic** - እንግዳርን ከማን ከሚከንፈስ ከ 1-855-856-0038 እን ይስራ ከማን.
- **Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038.
- **Armenian** - Տելեֆոնային կապը կատարեք 1-855-856-0038 անվճար գումարով.
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.
- **Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-856-0038 ku busa.
- **Bengali-Bangala** - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-856-0038-তে কল করুন।
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.
- **Burmese** - သီးသီးချင်း ကြည့်စွာ ထားလိုက်ပြီ။ 1-855-856-0038 မောင်မှု့ကြည်စွာကြည့်စွာ။
- **Catalan** - Per rebrer assistència en (català), truquí al número gratuit 1-855-856-0038.
- **Chamorro** - Para ayuda gi fino' (Chamoru), ågang 1-855-856-0038 sin gástu.
- **Cherokee** - ႯᏣᎳᏗᏞᏏᏨ.ᏯᏣᎳ.ᏯᏣᎳᏏᏳᏗᏗᏣᏯᏣᏗ (GWW) ᏣᎳᎴᏣᏗ 1-855-856-0038 OPᏣᎳᏭ ᎠᏣᎳᏣ.jEG.P.I hPRO.
- **Chinese** - 欲取得繁體中文語言協助，請撥打1-855-856-0038，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-855-856-0038.
- **Cushite** - Gargaarsa afaan Oromiffa hiikku argachuuf lakkokkofs bilbilaa 1-855-856-0038 irratti bilisana bilbilaa.
- **Dutch** - Bel voor tolk- en vertaalstenen in het Nederlands gratis naar 1-855-856-0038.
- **French** - Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.
- **German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.
- **Gujarati** - ગુજરાતીમાં ભાષા સહાય માટે કોઈપણ વર્ષ વગર 1-855-856-0038 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka aŋsũ na Igbo kpǒ 1-855-856-0038 na akwughi ʊgwọ ọ bula

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.

Japanese - 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。

Karen - Bèm kē gbo-kpā- kpā dyé pidyi qé Basoowuq̱ ńuqun wée, qá 1-855-856-0038

Kurdish - برای راهنمايی به زبان فارسي با شماره 1-855-856-0038 گفتگو کنید.

Laotian - Ñan bôk jîpā ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wònān.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा.

Marshallese - Ohng palien sawas en souν kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.

Mon-Khmer - T'áá shiaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí kojì' t'áá jík'e hólne' 1-855-856-0038

Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਫੋਨ ਕਰੋ।

Persian - برای راهنمايی به زبان فارسي با شماره 1-855-856-0038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.
Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.

Pentru asistență lingvistică în română le telefonați la numărul gratuit 1-855-856-0038.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.

Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-856-0038.

Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-855-856-0038. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-855-856-0038 ‘o ‘ikai hā ʻōtōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-855-856-0038 nge esapw kamé nгонuk.

(Dil) çağrı dil yardım için. Hiçbir ücret ödemeden 1-855-856-0038.

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.

ا یرگی گنت م ریب 1-855-856-0038 (سیکیستان) و او مین ولی ری م و در

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-855-856-0038.

פאר שפארו יהילו אנ' אידיש רופא. 1-855-856-0038

Fún iránlọwọ nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.