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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

### Important Questions

| What is the overall deductible? | In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,500 / Family $3,000. | 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. |
| Are there services covered before you meet your deductible? | Yes. In-network generic drugs; plus in-network preventive care are covered before you meet your deductible. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges & health care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the out–of–pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of In-Network providers. | 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. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |
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>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<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>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician. Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year. 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></td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Deductible doesn't apply: $6 copay/30 days (retail), $14 copay/90 days</td>
<td>Deductible doesn't apply: $6 copay plus billed amount minus contracted rate/30 days (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order, UVA pharmacies, CVS pharmacies). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to deductible or out-of-pocket limit. Maintenance drugs- after two retail fills, members</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetnapharmacy.com/standard">www.aetnapharmacy.com/standard</a></td>
<td>Preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $34 min/$200 max 30 days (retail); 20% coinsurance with $75 min/$425 max 90 days</td>
<td>After deductible, 20% coinsurance with $34 min/$200 max plus billed amount minus contracted rate/30 days (retail)</td>
<td></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>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<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>
<td>are required to fill a 90-day supply at UVA Pharmacies, CVS Caremark® Mail Service Pharmacy or CVS Pharmacies. Deductible doesn't apply to certain preventive &amp; chronic medications.</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $68 min/$275 max 30 days (retail); 20% coinsurance with $150 min/$525 max 90 days</td>
<td>After deductible, 20% coinsurance with $68 min/$275 max plus billed amount minus contracted rate/30 days (retail)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</td>
<td>After deductible, G: 20% coinsurance with $150 max; P: 20% coinsurance with $200 max; N: 20% coinsurance with $350 max</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 35% coinsurance | None |
|                               | Physician/surgeon fees | 15% coinsurance | 35% coinsurance | None |

| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use. |
|                                       | Emergency medical transportation | 15% coinsurance | 15% coinsurance | Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized. |
|                                       | Urgent care | 15% coinsurance | 15% coinsurance | No coverage for non-urgent use. |

| If you have a hospital stay | Facility fee (e.g., hospital room) | 15% coinsurance | 35% coinsurance | Pre-authorization required for out-of-network care. |
|                            | Physician/surgeon fees | 15% coinsurance | 35% coinsurance | None |

| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: 15% coinsurance | Office & other outpatient services: 35% coinsurance | None |
|                                                                         | Inpatient services | 15% coinsurance | 35% coinsurance | Pre-authorization required for out-of-network care. |

<p>| If you are pregnant | Office visits | No charge for routine services | 35% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. Childbirth/delivery professional services) | 35% coinsurance |</p>
<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 need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- 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 - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - Limited to Institutes of Quality contracted facility only.
- Chiropractic care - 26 visits/calendar year.
- Hearing aids - $1,200 maximum/48 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

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:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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**: $500
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,700</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $60

**The total Peg would pay is**: $2,270

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

- **The plan’s overall deductible**: $500
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $20

**The total Joe would pay is**: $1,320

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

- **The plan’s overall deductible**: $500
- **Specialist coinsurance**: 15%
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions: $0

**The total Mia would pay is**: $910

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 866-393-0002.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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.
Language Assistance:
For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë nё gjuhën shqipe telefononi falas nё 1-800-370-4526.
Amharic - እርትካታ ከمري መ ከምርን የ1-800-370-4526 ያሆ የፌካን ከምርን ያሆ
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526 2026
Armenian - Ներկա գրավորություն ապահովություն (հայերեն) կարող 1-800-370-4526 անմիջական գնով;
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese - မြန်မာစိုး အသင်္ဃပာ သို့ (缅文) သို့ 1-800-370-4526 စေပုံညတာက်
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro - Para ayuda gi fino’ (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee - ᎠᏣᎢᏲ ᏣᎨᏳ ᏣᏝᏪ ᎠᏣᏲ ὍΧ Τ (GWV) OΘΩ18 1-800-370-4526 ΩΘ Λ ΑΓΕΘΙ ΗΦΕΘΩ.
Chinese - 欲取得繁體中文語言協助，請撥打1-800-370-4526，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-370-4526.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkoikkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય માટે કોઈ પણ અર્થ વચ્ચે 1-800-370-4526 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi - 1-800-370-4526

Hmong - 1-800-370-4526

Ibo - 1-800-370-4526

Ilocano - 1-800-370-4526

Italian - 1-800-370-4526

Japanese - 1-800-370-4526

Karen - 1-800-370-4526

Korean - 1-800-370-4526

Kru-Bassa - 1-800-370-4526

Kurdish - 1-800-370-4526

Laotian - 1-800-370-4526

Marathi - 1-800-370-4526

Marshallese - 1-800-370-4526

Micronesian - 1-800-370-4526

Nilotic-Dinka - 1-800-370-4526

Norwegian - 1-800-370-4526

Panjabi - 1-800-370-4526

Pennsylvania Dutch - 1-800-370-4526

Persian - 1-800-370-4526

Polish - 1-800-370-4526

Portuguese - 1-800-370-4526

Romanian - 1-800-370-4526

Spanish - 1-800-370-4526

Swahili - 1-800-370-4526

Tagalog - 1-800-370-4526

Tamil - 1-800-370-4526

Tongan - 1-800-370-4526

Turkish - 1-800-370-4526

Ukrainian - 1-800-370-4526

Ukrainian - 1-800-370-4526

Vietnamese - 1-800-370-4526

Yoruba - 1-800-370-4526

Zulu - 1-800-370-4526


calls are free in the United States and Canada.

1-800-370-4526 is also available in areas outside the United States and Canada.
To get help from a Russian-speaking translator, call the free number 1-800-370-4526.

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatnoj broj 1-800-370-4526.

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

খালে হাসেল একাকী মালোটের বিপদের 1-800-370-4526 যে বন্ধ চ্যালেন্স।

สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ētōngi.

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

(Dil) çağrısi dil yardım için. Hiçbir ücret ödedemen 1-800-370-4526.

Щоб отримати допомогу перекладача української мови, зв’яжіться за безкоштовним номером 1-800-370-4526.

Để được hỗ trợ ngôn ngữ (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Fún irànńlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rará.