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, visit www.mymta.info or by calling 1-646-376-0123. 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 1-646-376-0123 to request a copy.

### Important Questions

<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>Network: Individual $0 / Family $0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 for durable medical equipment. There are no other specific deductibles.</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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Not Applicable</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Not Applicable</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetnaNYCT.com">www.aetnaNYCT.com</a> or call 1-855-824-5349 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>No.</td>
<td>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></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 visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>Not covered</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 drugs to treat your illness or condition</td>
<td><strong>Generic drugs – Your Lowest Cost-Option</strong></td>
<td><strong>In-Network Provider</strong> (You will pay the least): Retail/Specialty Medications: 1-30 day: $0 copay; Mail Order Medications: 31-90 day: $0 copay; Mail order Specialty Medications: 30 day: $0 copay</td>
<td>You will pay the cost of the medication and submit a paper claim for possible reimbursement. Provider means network pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail Order: Up to a 90 day supply. Mail Order Specialty: up to 30 day supply. See the website listed for information on drugs covered by your plan. Not all drugs are covered.</td>
</tr>
<tr>
<td>Prescription drug coverage is administered by Express Scripts</td>
<td><strong>Preferred brand drugs – Your Mid-Range Cost Option</strong></td>
<td><strong>In-Network Provider</strong> (You will pay the least): Retail/Specialty Medications: 1-30 day: $10 copay; Mail Order/Specialty Medications: 31-90 day: $20 copay</td>
<td>You will pay the cost of the medication and submit a paper claim for possible reimbursement.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td><strong>Non-preferred brand drugs – Your Highest-Cost Option</strong></td>
<td><strong>In-Network Provider</strong> (You will pay the least): Retail/Specialty Medications: 1-30 day: $15 copay; Mail Order Medications: 31-90 day: $30 copay; Mail order Specialty Medications: 30 day: $0 copay</td>
<td>You will pay the cost of the medication and submit a paper claim for possible reimbursement.</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td><strong>Applicable cost as noted above for generic or brand drugs</strong></td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most): You will pay the cost of the medication and submit a paper claim for possible reimbursement.</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</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>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>0% coinsurance after specific deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</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:

**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
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

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 1-646-376-0123.
- 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 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 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 1-646-376-0123.
- 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 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.
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: $0
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $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**: $12,800

**In this example, Peg would pay:**

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

**What isn’t covered**
- Limits or exclusions: $200

**The total Peg would pay is**: $200

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

- The plan’s overall deductible: $0
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $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**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $2,900

**The total Joe would pay is**: $3,000

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

- The plan’s overall deductible: $0
- Specialist copayment: $0
- Hospital (facility) copayment: $0
- Other copayment: $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**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</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**: $1,900

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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 1-646-376-0123.

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 1-646-376-0123.

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 (Aetna).
TTY: 711

Language Assistance:
For language assistance in your language call 1-646-376-0123 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-646-376-0123.
Amharic - እንጋጌ ከጆም ከ ከምር መ 1-646-376-0123 ይታሸ ይጋሚ.
Arabic - للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني 1-646-376-0123.
Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-646-376-0123 առանց գնի:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-646-376-0123 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-646-376-0123 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বনিমুলুক 1-646-376-0123-ভে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-646-376-0123 nga walay bayad.
Burmese - ေငြကုန္က်ခံစရာမလိုဘဲ (ျမန္မာဘာသာစကား)ျဖင့္ ဘာသာစကားအကူအညီရယူရန္ 1-646-376-0123 ကို ေခၚဆိုပါ။
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-646-376-0123.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-646-376-0123 sin gāstu.
Cherokee - ოოო ოო ოო ოო ოო ტ გ (GWW) ობორო 1-646-376-0123 ე-ს ტ ლ აგო ოი ოი ოი ოი ოი ოი ოი ოი ოი ოი ოი ოი ოი.
Chinese - 欲取得繁體中文語言協助，請撥打 1-646-376-0123，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi ! paya hinla 1-646-376-0123.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-646-376-0123 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-646-376-0123.
French - Pour une assistance linguistique en français appeler le 1-646-376-0123 sans frais.
French Creole - Pou jwenn asitans nan lang Kreyòl Ayisyen, rele nimewo 1-646-376-0123 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-646-376-0123 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-646-376-0123 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં લાભ માટે કોઈ પણ પરસ્પર વાત 1-646-376-0123 પર કોઈ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-646-376-0123. Kāki ‘ole ia kēia kōkua nei.

हिन्दी में भाषा सहायता के लिए, 1-646-376-0123 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-646-376-0123.

Maka enyemaka asusũ na Igbo kpoo 1-646-376-0123 na akwụghị ụgwọ ọ bụla

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-646-376-0123 nga awan ti bayadanyo.

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-646-376-0123.

日本語で援助をご希望の方は、1-646-376-0123 まで無料でお電話ください。

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-646-376-0123번으로 전화해 주십시오.

Kru-Bassa - Ìɛ̀ m̀ ké gbo-kpá-kpá dyé piády dë Baŋсо-wuŋwëŋ wëdë, dë 1-646-376-0123

ब्राइन बंगाली भाषा योग्यता के लिए, 1-646-376-0123 के घर मुफ्त कॉल करें।

Laotian - thinly bangtan bangtaw lao kew te thamphathakalo, khalapaiw kai 1-646-376-0123 dai yai yeu chilai.

तीलभाषा (मराठी) सहाय्यासाठी 1-646-376-0123 करतोकायाक्षणों充当哈拉行。राजीव मारतीनारा

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-646-376-0123 ilo ejielok wōnān.

Ohng palien sawas en soum kawewe ni omw loka Ponape koahl 1-646-376-0123 ni sohte isais.

Nyancha'ny fahamasan'ny lanjoany ny fiainatondra sy fiainatondra hoanteo aho 1-646-376-0123 ni ohatra fitovitrai.

T'áá shi shizaad k'ehjí bee shíká a'doowol ninizíng Díñe k'ehjí kojí t'áá jíík'e hólne' 1-646-376-0123

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-646-376-0123 मा फोन गरुन्यो।

Tën kuóonjë thok è Thuangjän col 1-646-376-0123 kecïn ayoc.

For språkkassistance på norsk, ring 1-646-376-0123 kostnadsfritt.

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-646-376-0123.
Para obter assistência linguística em português ligue para o 1-646-376-0123 gratuitamente.

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-646-376-0123

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-646-376-0123.

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