



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, call 1-888-383-0132 or visit welcometouhc.com. 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 www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Designated <u>Network</u> : \$3,500 Individual / \$10,500 Family <u>Network</u> : \$3,500 Individual / \$10,500 Family Designated <u>network</u> and <u>network deductibles</u> cross apply. Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Designated <u>Network</u> : \$7,900 Individual / \$15,800 Family <u>Network</u> : \$7,900 Individual / \$15,800 Family Designated <u>network</u> and <u>network out-of-pocket limits</u> cross apply. Per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	Yes. See www.myuhc.com or call 1-888-383-0132 for a list of <u>network providers</u> .	You will pay the least if you use a <u>provider</u> in the Designated <u>Network</u> . You pay more if you use a <u>provider</u> in the <u>Network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Designated <u>Network</u> : \$20 <u>copay</u> per visit, <u>deductible</u> does not apply <u>Network</u> : \$40 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Not Covered	<u>Primary Care Physician</u> must be assigned to member. Primary Care includes <u>network</u> OB/GYNs – no <u>referral</u> required. Virtual Visits - No Charge by a Designated Virtual <u>Network Provider</u> . No <u>referral</u> required. Under age 19 - Network visits are covered at No Charge. Office Visit cost share applies to any other Telehealth service based on <u>provider</u> type If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist visit</u>	Designated <u>Network</u> : \$40 <u>copay</u> per visit, <u>deductible</u> does not apply <u>Network</u> : \$80 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Not Covered	We only accept electronic referrals from the assigned PCP. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.

	<u>Preventive care/ screening/ immunization</u>	No Charge	Not Covered	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
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* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Tier 1 - Your Lowest Cost Option	\$20 retail - \$50 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$20 retail - \$50 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply.
	Tier 2 - Your Mid-Range Cost Option	\$50 retail - \$125 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$50 retail - \$125 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	<u>Out-of-Network</u> mail order is not covered.
	Tier 3 - Your Mid-Range Cost Option	\$100 retail - \$250 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	\$100 retail - \$250 mail <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	Specialty drugs	\$20/\$50/\$100 <u>copay</u> /prescription	Not Applicable	Not Applicable	<u>Specialty drugs</u> must be obtained from the CVS Caremark Specialty Pharmacy Network. Mail order is not covered. Anti-Obesity Management medications will have a \$100 copay/prescription, deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	Not Covered	None
	Physician/surgeon fees	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$1,250 <u>copay</u> per visit then 20% <u>coinsurance</u>	\$1,250 <u>copay</u> per visit then 20% <u>coinsurance</u>	\$1,250 <u>copay</u> per visit then 20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent Care</u>	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply	\$100 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	Not Covered	None
	Physician/surgeon fees	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	<u>Network</u> All Other: 20% <u>coinsurance</u> Intensive Behavior Therapy (ABA): \$20 <u>copay</u> per visit, <u>deductible</u> does not apply
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	None
If you are pregnant	Office Visits	No Charge	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Designated <u>Network</u> : 20% <u>coinsurance</u> <u>Network</u> : 40% <u>coinsurance</u>	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider with Referral (You will pay the least)	Network Provider without Referral (You may pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 visits per calendar year.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Limits per calendar year: Cardiac, Pulmonary: 36 visits each; Physical, Occupational, Speech: 60 visits each.
	<u>Habilitative services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply	Not Covered	Services are provided under and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	Limited to 60 days per calendar year, (combined with inpatient rehabilitation).
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	Covers 1 per type of DME (including repair/ replacement) every 3 years.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Children's dental check-up.

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 | • Glasses | • Private duty nursing |
| • Bariatric surgery | • Infertility Treatment | • Routine Eye Care |
| • Cosmetic Surgery | • Long Term Care | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | • Non-emergency care when traveling outside - the US | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | |
|--|--|
| • Chiropractic (manipulative) care - 20 visits per calendar year | • Hearing aids - \$2,500 per 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: [the Member Service number listed on the back of your ID card or myuhc.com](#).

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

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 the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-383-0132.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-888-383-0132.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-383-0132

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-383-0132uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-383-0132

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-383-0132

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-383-0132

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-383-0132

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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:
Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,070

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,650

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,200
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزاي والتغطية هذا. (Summary of Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage- SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការបង្កង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłt'i'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shqódí Naaltsoos Bee 'Aa'ahayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíłnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).