



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [welcometouhc.com](http://welcometouhc.com) or by calling 1-866-314-0335.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>Network: <b>\$1,500</b> *Individual / <b>\$3,000</b> Family            Non-Network: <b>\$3,000</b> *Individual / <b>\$6,000</b> Family            Per calendar year.            Services listed below as "No Charge" do not apply to the <b>deductible</b>.            *Doesn't apply if policy covers 2+ people.</p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p>Network: <b>\$2,750</b> *Individual / <b>\$5,500</b> Family            Non-Network: <b>\$6,500</b> *Individual / <b>\$13,000</b> Family            *Doesn't apply if policy covers 2+ people.</p>	<p>The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p><b>Premium</b>, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain Pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p><b>Is there an overall annual limit on what the plan pays?</b></p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</p>
<p><b>Does this plan use a <u>network of providers</u>?</b></p>	<p>Yes. For a list of <b>network providers</b>, see <a href="http://myuhc.com">myuhc.com</a> or call 1-866-314-0335.</p>	<p>If you use an in-network doctor or other health care <b>provider</b>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p>
<p><b>Do I need a referral to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <b>specialist</b> you choose without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b>.</p>

**Questions:** Call 1-866-314-0335 or visit us at [welcometouhc.com](http://welcometouhc.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf](http://cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf) or call the phone number above to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% co-ins after ded.	40% co-ins after ded.	Virtual visits (Telehealth) – 20% co-ins after deductible per visit by a designated virtual network provider. No virtual coverage out-of-network.
	Specialist visit	20% co-ins after ded.	40% co-ins after ded.	None
	Other practitioner office visit	20% co-ins after ded.	40% co-ins after ded.	Cost share applies to manipulative (chiropractic) services only and is limited to 60 visits per calendar year.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins after ded.	40% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	40% co-ins after ded.	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: 20% co-ins after ded. up to a maximum of \$300 Mail-Order: 20% co- ins after ded. up to a maximum of \$750	Retail: 20% co-ins after ded. up to a maximum of \$300	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
More information about <b>prescription drug coverage</b> is available at <a href="http://myuhc.com">myuhc.com</a>	Tier 2 – Your Midrange-Cost Option	Retail: 20% co-ins after ded. up to a maximum of \$300 Mail-Order: 20% co- ins after ded. up to a maximum of \$750	Retail: 20% co-ins after ded. up to a maximum of \$300	notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coins may be applied. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug costs are subject to the annual deductible.
	Tier 3 – Your Highest-Cost Option	Retail: 20% co-ins after ded. up to a maximum of \$300 Mail-Order: 20% co- ins after ded. up to a maximum of \$750	Retail: 20% co-ins after ded. up to a maximum of \$300	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	40% co-ins after ded.	None
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None
<b>If you need immediate medical attention</b>	Emergency room services	20% co-ins after ded.	*40% co-ins after ded.	*Network deductible applies
	Emergency medical transportation	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies
	Urgent care	20% co-ins after ded.	40% co-ins after ded.	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	20% co-ins after ded.	40% co-ins after ded.	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental / Behavioral health outpatient services	20% co-ins after ded.	40% co-ins after ded.	Partial hospitalization/intensive outpatient treatment:20% coinsurance after deductible Pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Mental / Behavioral health inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	20% co-ins after ded.	40% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible Pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Substance use disorder inpatient services	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
<b>If you are pregnant</b>	Prenatal and postnatal care	No Charge	40% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	40% co-ins after ded.	Inpatient pre-notification may apply.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-ins after ded.	40% co-ins after ded.	Limited to 60 visits per calendar year. Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	20% co-ins after ded.	40% co-ins after ded.	Limited to 60 visits per therapy, per calendar year.
	Habilitative services	20% co-ins after ded.	40% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	20% co-ins after ded.	40% co-ins after ded.	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% co-ins after ded.	40% co-ins after ded.	Pre-notification is required non-network for DME over \$1,000 or benefit reduces to 50% of eligible expenses. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	20% co-ins after ded.	40% co-ins after ded.	Limited to 360 days per calendar year. Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	20% co-ins after ded.	Not Covered	Limited to 1 exam every 2 years. No coverage non-network.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

### Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult/Child)</li> </ul>	<ul style="list-style-type: none"> <li>Glasses (Adult/Child)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> <li>Routine eye care (Adult/Child)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> </ul>

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-314-0335.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-314-0335.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-314-0335.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-0335.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

## Coverage Examples

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Coverage for: Employee & Family      Plan Type: PS1

#### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,840
- Patient pays \$2,700

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40

**Total \$7,540**

#### Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$200

**Total \$2,700**

#### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,160
- Patient pays \$2,240

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100

**Total \$5,400**

#### Patient pays:

Deductibles	\$1,500
Copays	\$0
Coinsurance	\$700
Limits or exclusions	\$40

**Total \$2,240**

## Questions and answers about Coverage Examples:

<p><b>What are some of the assumptions behind the Coverage Examples?</b></p> <ul style="list-style-type: none"> <li>Costs don't include <b>premiums</b>.</li> <li>Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.</li> <li>The patient's condition was not an excluded or preexisting condition.</li> <li>All services and treatments started and ended in the same coverage period.</li> <li>There are no other medical expenses for any member covered under this plan.</li> <li>Out-of-pocket expenses are based only on treating the condition in the example.</li> <li>The patient received all care from in-network <b>providers</b>. If the patient had received care from out-of-network <b>providers</b>, costs would have been higher.</li> <li>If other than individual coverage, the Patient Pays amount may be more.</li> </ul>	<p><b>What does a Coverage Example show?</b></p> <p>For each treatment situation, the Coverage Example helps you see how <b>deductibles</b>, <b>copayments</b>, and <b>coinsurance</b> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p><b>Can I use Coverage Examples to compare plans?</b></p> <p>✓ <b>Yes.</b> When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
	<p><b>Does the Coverage Example predict my own care needs?</b></p> <p>✗ <b>No.</b> Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p><b>Are there other costs I should consider when comparing plans?</b></p> <p>✓ <b>Yes.</b> An important cost is the <b>premium</b> you pay. Generally, the lower your <b>premium</b>, the more you'll pay in out-of-pocket costs, such as <b>copayments</b>, <b>deductibles</b>, and <b>coinsurance</b>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p><b>Does the Coverage Example predict my future expenses?</b></p> <p>✗ <b>No.</b> Coverage Examples are <b>not</b> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <b>providers</b> charge, and the reimbursement your health plan allows.</p>	

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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.

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**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 هنا. (Summary of Benefits and Coverage- SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè 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 និងការ៉ាបង់រង (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 yániti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shòqdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíik'ehgo béésh bee hane'í biká'ígíí bee hodílnih.

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).