




## UHC Choice Plus (PPO)



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 [getsalesforcebenefits.com](https://www.getsalesforcebenefits.com) or call 1-855-376-5627. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-844-234-1202 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <b>What is the overall <u>deductible</u>?</b>                             | <u>Network</u> *: \$500 Individual / \$1,500 Family<br><u>Non-Network</u> *: \$1,000 Individual / \$3,000 Family per calendar year. * <u>Deductibles</u> cross-apply<br>Does not apply to copays, pharmacy drugs, and services listed below as “No Charge”. | Generally, you must pay all of the costs from providers 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> .   |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive Care</u> and <u>primary care services</u> with <u>copay</u> are 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 <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 <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No, there are no other <u>deductibles</u> .   | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.  |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | Medical- For <u>network provider</u> *: \$2,500 Individual / \$4,500 Family<br>For out-of- <u>network</u> providers*: \$5,000 Individual / \$9,000 Family per calendar year<br>*Out-of-pockets cross-apply  | 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.  |

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>   | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>   | Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-844-234-1202 for a list of <u>network providers</u> .                                    | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No   | You can see the <u>specialist</u> you choose without a <u>referral</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  |
|--|--|---|---|---|
|  |  | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |   |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$15 <u>copay</u> /visit                            | 30% <u>coinsurance</u>                                    | Virtual Visit-In <u>network</u> \$15 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . No virtual coverage out of <u>network</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-ins may apply. |
|  | <u>Specialist</u> visit                          | \$15 <u>copay</u> /visit                            | 30% <u>coinsurance</u>                                    | None  |

| Common Medical Event   | Services You May Need                         | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | <u>Network Provider</u><br>(You will pay the least)        | <u>Out-of-Network Provider</u><br>(You will pay the most) |   |
|  | <u>Preventive care/screening/immunization</u> | No charge  | 30% <u>coinsurance</u>                                    | Includes preventive health services specified in the health care reform law.<br><br>You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test   | <u>Diagnostic test</u> (x-ray, blood work)    | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                    | None  |
|  | Imaging (CT/PET scans, MRIs)                  | 10% <u>coinsurance</u>                                     | 30% <u>coinsurance</u>                                    | None  |
| If you need drugs to treat your illness or condition<br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.CVS.com">www.CVS.com</a></b> | Generic Drugs (Tier 1)                        | Retail: \$10 <u>copay</u><br>Mail Order: \$20 <u>copay</u> | Retail: N/A<br>Mail Order: N/A                            | Pharmacy benefits are provided CVS/Caremark, please check separate summaries for benefit details.   |
|  | Preferred brand drugs (Tier 2)                | Retail: \$25 <u>copay</u><br>Mail Order: \$50 <u>copay</u> | Retail: N/A<br>Mail Order: N/A                            | Pharmacy benefits are provided CVS/Caremark, please check separate summaries for benefit details.   |
|  | Non-preferred brand drugs (Tier 3)            | Retail: \$40 <u>copay</u><br>Mail Order: \$80 <u>copay</u> | Retail: N/A<br>Mail Order: N/A                            | Pharmacy benefits are provided CVS/Caremark, please check separate summaries for benefit details.   |

| Common Medical Event                           | Services You May Need                          | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|--|--|--|---|--|
|  |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                        |  |
|  | <u>Specialty drugs</u><br>(Tier 4)             | Applicable cost as noted for generic or brand drugs<br><br>Generic (Tier 1): \$10 <u>copay</u><br>Preferred (Tier 2): \$20 <u>copay</u><br>Non-Preferred (Tier 3): \$40 <u>copay</u> | Retail: N/A<br>Mail Order: N/A  | 1 grace retail fill for a 30-day supply of specialty medicines at any network pharmacy. (Ongoing specialty fills must be dispensed through CVS Specialty Pharmacy and/or may be picked up at a CVS Pharmacy.)<br><br>Some specialty medications may qualify for third-party copayment assistance programs that could lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate. |
| <b>If you have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>  | None   |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>  | None   |
| <b>If you need immediate medical attention</b> | <u>Emergency room care</u>                     | \$75 <u>copay</u> /visit 10% <u>coinsurance deductible</u> does not apply  | \$75 <u>copay</u> /visit 10% <u>coinsurance deductible</u> does not apply | None   |
|  | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>   | 10% <u>coinsurance</u>  | None   |
|  | <u>Urgent care</u>                             | \$15 <u>copay</u> /visit   | 30% <u>coinsurance</u>  | None   |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>  | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty   |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u>   | 30% <u>coinsurance</u>  | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty   |

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)         |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$15 <u>copay</u> /visit                     | 30% <u>coinsurance</u>                                     | None  |
|  | Inpatient services                        | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty                                      |
| <b>If you are pregnant</b>   | Office visits                             | \$15 <u>copay</u> /initial visit only        | 30% <u>coinsurance</u>                                     | Routine Pre natal care is covered at no charge  |
|  | Childbirth/delivery professional services | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     |   |
|  | Childbirth/delivery facility services     | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     |   |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty<br><br>120 visits per calendar year. |
|  | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     | 60 Visits per calendar year   |
|  | <u>Habilitation services</u>              | 10% <u>coinsurance</u>                       | \$15 <u>copay</u> /visit, 30% <u>coinsurance</u>           | 60 Visits per calendar year for Speech Therapy only.  |
|  | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty<br><br>60 days per calendar year     |
|  | <u>Durable medical equipment</u>          | No charge                                    | 50% <u>coinsurance</u><br><u>deductible</u> does not apply | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
|  | <u>Hospice services</u>                   | 10% <u>coinsurance</u>                       | 30% <u>coinsurance</u>                                     | Out of <u>Network</u> \$400 failure to Prior Authorize Penalty                                      |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | Not covered                                  | Not covered  | Not Covered   |
|  | Children's glasses                        | Not covered                                  | Not covered  | Not Covered   |
|  | Children's dental check-up                | Not covered                                  | Not covered  | Not Covered   |

**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.)**

|   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Adult routine vision exam (i.e. refraction)</li> <li>• Child dental check-up</li> <li>• Child routine vision exam (i.e. refraction)</li> </ul> | <ul style="list-style-type: none"> <li>• Child vision glasses</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul> |
|---|---|--|

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

|   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery – Limited to in-network</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids - - \$5,000 maximum per year</li> <li>• Infertility treatment – See Progyny documents for additional covered services</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul> |
|---|--|---|

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: 1-844-234-1202 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.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 1-844-234-1202.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-1202.

Chinese (中文): 如果需要中文的帮助, ☐☐☐☐☐☐☐ 1-844-234-1202.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-234-1202.

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

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## 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> | \$500 |
| ■ <u>Specialist copayment</u>                 | \$15  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$500          |
| <u>Copayments</u>                 | \$15           |
| <u>Coinsurance</u>                | \$1,218        |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,793</b> |

### 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> | \$500 |
| ■ <u>Specialist copayment</u>                 | \$15  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$100          |
| <u>Copayments</u>                 | \$900          |
| <u>Coinsurance</u>                | \$458          |
| <u>What isn't covered</u>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,478</b> |

### Mia's Simple Fracture

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

|   |       |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist copayment</u>                 | \$15  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$500        |
| <u>Copayments</u>                 | \$100        |
| <u>Coinsurance</u>                | \$220        |
| <u>What isn't covered</u>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$820</b> |





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).

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

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.

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 និងការកំបាំង (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 yánilti'go, saad bee áka'anída'awo'ígú, t'áá júk'eh, bee ná'ahóót'i'. T'áá shqodí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá júk'ehgo béesh bee hane'í biká'ígú 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).