UnitedHealthcare®
A UnitedHealth Group Company

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SUMMIT REHAB LLC
1405 4TH AVE NW 296
ARDMORE, OK 734010000

Dear Customer:

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

If you are an Employer, you can find your group's SBC documents by logging into www.employereservices.com and select "Summary of Benefits and Coverage" under the Resources menu.

For more information regarding this document, please visit uhc.com/summary or contact the Member Services number on the back of your ID card.

Very truly yours,

Christopher Hock
Broker & Employer Operations
UnitedHealthcare

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 **www.welcometouhc.com** or by calling **1-800-782-3158.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$1,000** Indiv **/ $3,000** Family Non-Network: **$5,000** Indiv **/ $15,000** Family Per calendar year. Does not apply to prescription drugs, services listed below as "No Charge" and copays except as noted below.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Network: **$5,000** Indiv **/ $12,700** Family Non-Network: **$10,000** Indiv **/ $30,000** Family	The **out-of-pocket limit** 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3158.**	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-782-3158** or visit us at **www.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 **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** 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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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 Designated Network Provider	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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	$25 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider. Children under age 19: No Charge.
	Specialist visit	$25 copay per visit	$50 copay per visit	50% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25 copay per visit	$25 copay per visit	50% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services. Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
	Preventive care / screening/im-munization	No Charge	No Charge	30% co-ins, after ded *	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	30% co-ins, after ded	Pre-Authorization required for non-network for sleep studies or benefit reduces by $500 per occurrence.
	Imaging (CT/PET scans, MRIs)	$400 copay per service	$400 copay per service	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com.	Tier 1 - Your Lowest-Cost Option	Retail: $15 copay Mail-Order: $37.50 copay Specialty Drugs: $15 copay	Retail: $15 copay Mail-Order: $37.50 copay Specialty Drugs: $15 copay	Retail: $15 copay Specialty Drugs: $15 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Authorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge. 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 co-ins may be applied.
	Tier 2 - Your Midrange-Cost Option	Retail: $40 copay Mail-Order: $100 copay Specialty Drugs: $100 copay	Retail: $40 copay Mail-Order: $100 copay Specialty Drugs: $100 copay	Retail: $40 copay Specialty Drugs: $100 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $70 copay Mail-Order: $175 copay Specialty Drugs: $300 copay	Retail: $70 copay Mail-Order: $175 copay Specialty Drugs: $300 copay	Retail: $70 copay Specialty Drugs: $300 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for certain services for non-network or benefit reduces by $500 per occurrence.
	Physician/surgeon fees	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$250 copay per visit. After Copay, 20% co-ins applies.	$250 copay per visit After Copay, 20% co-ins applies.	$250 copay per visit After Copay, 20% co-ins applies.	None
	Emergency medical transportation	20% co-ins, after ded	20% co-ins, after ded	20% co-ins, after ded	Network Deductible applies.
	Urgent care	$75 copay per visit	$75 copay per visit	50% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	$25 copay per visit	50% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 20% co-ins Pre-Authorization required for certain services for non-network or benefit reduces by $500 per occurrence.
	Mental/Behavioral health inpatient services	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
	Substance use disorder outpatient services	$25 copay per visit	$25 copay per visit	50% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 20% co-ins Pre-Authorization required for certain services for non-network or benefit reduces by $500 per occurrence.
	Substance use disorder inpatient services	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	50% 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	20% co-ins, after ded	50% co-ins, after ded	Inpatient Authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Limited to 60 visits per policy period. Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
	Rehabilitation services	$25 copay per outpatient visit	$25 copay per outpatient visit	50% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, 25 visits each. Pulmonary 20 visits. Cardiac 36 visits. Pre-Authorization required for certain services for non-network or benefit reduces by $500 per occurrence.

Common Medical Event	Services You May Need	Your Cost If You Use a Designated Network Provider	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Habilitative services	$25 copay per outpatient visit	$25 copay per outpatient visit	50% co-ins, after ded	Limits per policy period: Physical, Speech, Occupational, 25 visits (combined). Pre-Authorization required for certain services for non-network or benefit reduces by $500 per occurrence.
	Skilled nursing care	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Nursing limited to 30 days per policy period. (Inpatient Rehabilitation limited to 30 days). Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
	Durable medical equipment	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Pre-Authorization required for non-network DME over $1,000 or benefit reduces by $500 per occurrence.
	Hospice service	20% co-ins, after ded	20% co-ins, after ded	50% co-ins, after ded	Inpatient Pre-Authorization required for non-network or benefit reduces by $500 per occurrence.
If your child needs dental or eye care	Eye exam	$10 copay per visit	$10 copay per visit	50% co-ins, after ded	One exam every 12 months.
	Glasses	$25 copay per pair	$25 copay per pair	50% co-ins, after ded	One pair every 12 months. Cost may increase depending on the frames selected.
	Dental check-up	0% co-ins, after ded	0% co-ins, after ded	0% co-ins, after ded	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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 excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Chiropractic care
- Hearing aids
- Private-Duty Nursing

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 us at 1-800-782-3158 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Oklahoma Insurance Department at 1-800-522-0071 or www.ok.gov/oid.

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 1-800-782-3158 .

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158 .

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3158 .

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3158 .

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

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,420
- **Patient pays** $2,120

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	$1,000
Copays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$2,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,760
- **Patient pays** $1,640

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	$200
Copays	$1,400
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,640**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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.

Does the Coverage Example predict my own care needs?

✘ **No .** 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.

Does the Coverage Example predict my future expenses?

✘ **No .** Coverage Examples are **not** 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 **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes .** 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.

Are there other costs I should consider when comparing plans?

✓ **Yes .** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call **1-800-782-3158** or visit us at **www.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 **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

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
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 المزايا والتغطية (Summary of 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.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क 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។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (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 yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání 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 hodíilnih.

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).