



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 [Join.Surest.com](https://www.healthcare.gov/sbc-join-surest.com) or by calling Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$2,500 individual / \$5,000 family For <u>out-of-network providers</u> : \$8,000 individual / \$16,000 family	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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges and 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 Join.Surest.com , or call 1-866-683-6440 for a list of network providers.	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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copay 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 - \$40 <u>copay</u> /visit	\$120 <u>copay</u> /visit	<p>Certain procedures performed in the office may have a higher office visit <u>copay</u>. <u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. Virtual visits – No charge per visit by a Designated Virtual <u>Network Provider</u>. *Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional <u>copays</u> may apply.</p> <p>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.</p>
	<u>Specialist</u> visit	\$5 - \$40 <u>copay</u> /visit	\$120 <u>copay</u> /visit	
	<u>Preventive care/screening/immunization</u>	No charge	\$60 <u>copay</u> /visit	
If you have a test	<u>Diagnostic test</u> (e.g. x-ray, blood work)	<p>Routine <u>diagnostic test</u>: No charge</p> <p>Non-routine <u>diagnostic test</u>: \$10 - \$370 <u>copay</u>/visit</p>	<p>Routine <u>diagnostic test</u>: No charge</p> <p>Non-routine <u>diagnostic test</u>: Up to \$1,110 <u>copay</u>/visit</p>	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. <u>Preauthorization</u> is required for certain Non-routine <u>diagnostic tests</u> or your benefits may be reduced or there may be no coverage.</p>
	Imaging (CT/PET scans, MRIs)	\$50 - \$310 <u>copay</u> /visit	\$930 <u>copay</u> /visit	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. <u>Preauthorization</u> is required for certain imaging tests or your benefits may be reduced or there may be no coverage.</p>

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at Optumrx.com.</p>	Tier 1 drugs	30-Day Supply \$10 <u>copay</u> 90-Day Supply \$25 <u>copay</u>	Not covered	<p>Certain Tier 1 drugs are available with \$0 <u>copays</u>, including prescribed generic contraceptives and tobacco cessation medications. To learn more about drug tiers and about <u>copays</u> for specific drugs, visit Optumrx.com. <u>Preauthorization</u> is required for certain drugs or may result in a higher cost.</p>
	Tier 2 drugs	30-Day Supply \$20 <u>copay</u> 90-Day Supply \$50 <u>copay</u>	Not covered	
	Tier 3 drugs	30-Day Supply \$40 <u>copay</u> 90-Day Supply \$100 <u>copay</u>	Not covered	
	<u>Specialty drugs</u>	30-Day Supply Tier 1: \$100 <u>copay</u> Tier 2: \$130 <u>copay</u> Tier 3: \$150 <u>copay</u>	Not covered	

*For more information about limitations and exceptions, see plan or policy document at [Join.Surest.com](https://www.join.surest.com) for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$10 - \$2,000 <u>copay</u> /visit	Up to \$6,000 <u>copay</u> /visit	<p><u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Preauthorization</u> is required for certain outpatient surgery or your benefits may be reduced or there may be no coverage.</p>
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	<u>Emergency room care</u>	\$170 <u>copay</u> /visit	\$170 <u>copay</u> /visit	<p><u>Copay</u> is waived if admitted within 24 hours.</p> <p>Out-of-network <u>emergency room care</u> visit <u>copay</u> applies to the in-network <u>out-of-pocket limit</u>.</p>
	<u>Emergency medical transportation</u>	\$80 <u>copay</u> /transport	\$80 <u>copay</u> /transport	Out-of-network <u>emergency medical transportation copay</u> applies to the in-network <u>out-of-pocket limit</u> .
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	\$45 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 - \$2,000 <u>copay</u> /stay	Up to \$6,000 <u>copay</u> /stay	<p><u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Preauthorization</u> is required for non-emergency facility admissions and inpatient surgery or your benefits may be reduced or there may be no coverage.</p>
	Physician/surgeon fees	No charge	No charge	

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Home/Office: \$5 <u>copay</u> /visit Outpatient Facility: \$45 <u>copay</u> /visit	Home/Office: \$60 <u>copay</u> /visit Outpatient Facility: \$135 <u>copay</u> /visit	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> is required for certain outpatient services or your benefits may be reduced or there may be no coverage.
	Inpatient services	\$1,000 <u>copay</u> /stay	\$3,000 <u>copay</u> /stay	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Preauthorization</u> is required for certain inpatient services or your benefits may be reduced or there may be no coverage.
If you are pregnant	Office visits	No charge	\$60 <u>copay</u> /visit	<u>Cost sharing</u> does not apply to <u>preventive services</u> with <u>network providers</u> . Depending on the type of service, a <u>copay</u> may apply.
	Childbirth/delivery professional services	No charge	No charge	One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	\$350 - \$1,025 <u>copay</u> /stay	\$3,075 <u>copay</u> /stay	<u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care. <u>Preauthorization</u> is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or your benefits may be reduced or there may be no coverage.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	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>	\$15 <u>copay</u> /visit	\$45 <u>copay</u> /visit	Limited to 120 visits per person per <u>plan</u> year. <u>Preauthorization</u> is required for certain <u>home health care</u> services or your benefits may be reduced or there may be no coverage.
	<u>Rehabilitation services</u>	\$5 - \$35 <u>copay</u> /visit	Up to \$105 <u>copay</u> /visit	Limits per person per <u>plan</u> year: Occupational, physical and speech therapy: 60 visits each. Limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. <u>Copays</u> are listed as a range. Providers are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.
	<u>Habilitation services</u>	\$5 - \$35 <u>copay</u> /visit	Up to \$105 <u>copay</u> /visit	For mental health related therapies, see Section 1: Covered Health Care Services*.
	<u>Skilled nursing care</u>	\$800 <u>copay</u> /stay	\$2,400 <u>copay</u> /stay	Limited to 120 days per person per <u>plan</u> year. <u>Preauthorization</u> is required or your benefits may be reduced or there may be no coverage.
	<u>Durable medical equipment</u>	\$0 - \$500 <u>copay</u> /equipment based on <u>DME</u> tier	Up to \$1,000 <u>copay</u> /equipment based on <u>DME</u> tier	For <u>durable medical equipment (DME)</u> tiers and limitations, visit Join.Surest.com . <u>Preauthorization</u> is required for certain <u>DME</u> or your benefits may be reduced or there may be no coverage.
	<u>Hospice services</u>	Home: \$15 <u>copay</u> /visit Inpatient: \$1,000 <u>copay</u> /stay	Home: \$45 <u>copay</u> /visit Inpatient: \$3,000 <u>copay</u> /stay	None.
If your child needs dental or eye care	Children's eye exam	No Charge	\$120 <u>copay</u> /visit	Limited to 1 exam every year.
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for Children's dental check-up.

*For more information about limitations and exceptions, see plan or policy document at Join.Surest.com for prospective members.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Limitations apply)
- Routine Eye Care (Adult) (Limited to 1 exam every year.)
- Routine foot care (for certain conditions)

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 the agency is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cms.gov/ccio. You may also contact Surest Member Services at 1-866-683-6440. 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: Surest Member Services at 1-866-683-6440 or <https://www.michigan.gov/difs>.

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 1-866-683-6440.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
• The <u>plan's</u> overall <u>deductible</u>	\$0	• The <u>plan's</u> overall <u>deductible</u>	\$0	• The <u>plan's</u> overall <u>deductible</u>	\$0
• <u>Specialist copayment</u>	\$0	• <u>Specialist copayment</u>	\$10	• <u>Specialist copayment</u>	\$10
• <u>Hospital (facility) copayment</u>	\$1,025	• <u>Hospital (facility) copayment</u>	\$0	• <u>Hospital (facility) copayment</u>	\$170
• <u>Other copayments</u>	\$200	• <u>Other copayments</u>	\$600	• <u>Other copayments</u>	\$300
<p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic tests</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost sharing</u>		<u>Cost sharing</u>		<u>Cost sharing</u>	
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,225	<u>Copayments</u>	\$610	<u>Copayments</u>	\$480
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,245	The total Joe would pay is	\$610	The total Mia would pay is	\$480

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

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) هنا.

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 និងការរ៉ាប់រង (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 yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shòqdi Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíik'ehgo béesh 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).