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 https://humanresources.columbia.edu or call 1-212-851-7000. 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 1-212-851-7000 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $0 Individual / $0 Family Out-of-Network: Not Covered</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive Care and primary care services with copay are covered before you meet your deductible.</td>
<td>See the Common Medical Events Chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No, there are no other deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For Network providers: $3,500 Individual / $7,000 Family per calendar year For Out-of-Network providers: Not Covered</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket.</td>
</tr>
</tbody>
</table>
### Important Questions

| Will you pay less if you use a **network provider**? | Yes. See www.whyuhc.com/columbia or www.myuhc.com or call 1-800-232-9357 for a list of network providers. There is no coverage for Out-of-Network providers, except as outlined in the Common Medical Events chart. |
| Do you need a **referral** to see a **specialist**? | No |

**Why This Matters:**

This plan uses a provider network. You will pay less if you use a provider in the plan's network. Out-of-Network not covered. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

You can see the specialist you choose without a referral.

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay/visit</td>
<td>Not covered</td>
<td>UHC Virtual visit - In network $30 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays may apply. Other Telehealth providers are covered in network at applicable copay.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Not covered</td>
<td>$150 copay applies to outpatient hospital facility. No copay for NYP/Columbia or NYP/Weill Cornell Medical Centers.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$150 copay/test</td>
<td>Not covered</td>
<td>$150 copay applies to outpatient hospital facility. No copay for NYP/Columbia or NYP/Weill Cornell Medical Centers.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>Tier 1 – Lower cost Generic and some brand name Drugs</td>
<td>Retail: $10 copay Mail Order: $15 copay</td>
<td>Retail: Not covered</td>
<td>30 day supply retail; 90 day supply mail order. Certain preventive medications (including contraceptives) are covered at No Charge.</td>
</tr>
<tr>
<td></td>
<td>Tier II – Mid range cost Preferred brand name Drugs</td>
<td>Retail: $25 copay Mail Order: $50 copay</td>
<td>Retail: Not covered</td>
<td>30 day supply retail; 90 day supply mail order</td>
</tr>
<tr>
<td></td>
<td>Tier III – Higher cost Brand name and some generics</td>
<td>Retail: $45 copay Mail Order: $90 copay</td>
<td>Retail: Not covered</td>
<td>30 day supply retail; 90 day supply mail order</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 copay/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$150 copay/visit</td>
<td>$150 copay/visit</td>
<td>Emergency room copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>Non-Emergency ground and air transportation provided by a licensed professional ambulance is covered as UHC determines appropriate. Prior authorization required for non-emergency air ambulance or benefit will not be covered.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 copay/visit</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay/visit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$30 copay/visit</td>
<td>Employee Assistance Program (EAP) up to 6 sessions per subject covered at No Charge. Partial hospitalization/intensive outpatient treatment: No Charge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 copay/visit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$30 copay/initial visit only</td>
<td>Routine pre-natal care is covered at No Charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$500 copay/visit</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td>Home health care 200 visits per calendar year. Private duty nursing $5,000 per calendar year. One visit equals four hours of Skilled Care services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 copay/visit</td>
<td>Physical, Occupational combined 60 visits per calendar year. Cardiac, Cognitive, Pulmonary, Speech 60 visits each per calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Limit 120 days per calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Limit 120 days per calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>In Office: 100% in-network.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Limit 6 months per lifetime.</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>$10 copay/visit</td>
<td>Child under 19: Exam 100% after $10 copay. Limit 1 exam per 12 months.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>No charge</td>
<td>Not covered</td>
<td>Child under 19: Lenses or 1 pair/box contacts 100%. Frames up to $100 at 100%, 60% thereafter. Limit 1 per 12 months.</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Cosmetic Surgery</td>
</tr>
<tr>
<td>● Dental Care Adult &amp; Child Habilitation services</td>
</tr>
<tr>
<td>● Long-term care</td>
</tr>
<tr>
<td>● Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>● Routine foot care</td>
</tr>
<tr>
<td>● Weight loss programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>Limitations may apply to these services. This isn’t a complete list. Please see your plan document.</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Acupuncture</td>
<td></td>
</tr>
<tr>
<td>● Adult routine vision exam (i.e. refraction)</td>
<td></td>
</tr>
<tr>
<td>● Chiropractic care</td>
<td></td>
</tr>
<tr>
<td>● Hearing aids</td>
<td></td>
</tr>
<tr>
<td>● Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>● Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

**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/ 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: 1-800-232-9357 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or 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 1-212-851-7000.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-212-851-7000.
Navajo (Dine): Dine’ehgo shika a’ohbwo nínisingo, kwiijigo holnc’ 1-212-851-7000.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$30</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$500</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

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)

Total Example Cost: $12,700

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$30</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$500</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

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)

Total Example Cost: $5,600

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$30</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$500</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $2,800
In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $560

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $20 |

The total Joe would pay is $1,020

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is $400

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


**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 LUU Y: 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 đại 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.

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

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

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sevis 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。

Summary of Benefits and Coverage, SBC

ধ্যান দে: যদি আপ হিন্দি (Hindi) বলতে হয়, আপকে ভাষা সহায়তা সেবায়, নি:শুল্ক উপলব্ধ হয়। লাভ ও কভারেজ (Summary of Benefits and Coverage, SBC) কে ইসারান্থ কে ভিত্ত সুচীবদ্ধ টোল ফ্রি নং পর কাল করে।

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 Ntuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Neqi (Summary of Benefits and Coverage, SBC) no.

[hash] (Khmer) နှစ်စဉ် မြို့နယ်များ စီမံခန့်ဆောင်နိုင်သည်။ သေချာအောင် ဖြင့် သေချာပြုလုပ်သည်။ Benefits and Coverage, SBC

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyum. 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 yáníilt'go, saad bee áka'anída'wo'ígí, t'áá jiik'eh, bee ná'ahóó'í'. T'áá shqodí Naaltsoos Bee 'Aa'ahayáí dóó Bee 'Ak'è'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jiik'ehgo bée sh bee hane'i biká'ígí 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).