SSA Choice Plus 90

Coverage Period: 01/01/2020-12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Service

Coverage for: Employee/Family | Plan Type: PS1

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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>
</table>
| What is the overall deductible?                          | Network*: $400 per Individual per calendar year  
Non-Network*: $850 per Individual per calendar year. *Deductibles cross-apply Non-Network to Network. 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 deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive Care and categories with copay are covered before you meet your deductible.                                                              | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services?        | No, there are no other deductibles.                                                                                                                           | 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.               |
| What is the out-of-pocket limit for this plan?            | Network*: $3,250 Individual / $6,500 Family  
Non-Network*: $5,250 Individual / $10,500 Family per calendar year *Out-of-pockets cross-apply Non-Network to Network. | 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. |
| What is not included in the out-of-pocket limit?          | Premiums, out of network charges exceeding 190% of Medicare MAC, balance-billing charges, health care this plan doesn’t cover, penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don’t count toward the out-of-pocket.                                                                         |
### Important Questions | Answers | Why This Matters:
--- | --- | ---
**Will you pay less if you use a network provider?** | Yes. See www.columbia.welcometouhc.com or www.myuhc.com or call 1-800-232-9357 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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.

**Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</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><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out of Network Provider</strong> (You will pay the most)</td>
</tr>
</tbody>
</table>

| | | $30 Copay/visit | 40% Coinsurance |
| | Specialist visit | $30 Copay/visit | 40% Coinsurance |

| | | No Charge | 40% Coinsurance |

| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% Coinsurance | 40% Coinsurance |

**Important:** 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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out of Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>Retail: $10 Copay Mail Order: $15 Copay</td>
<td>Retail: Not Covered</td>
<td>Generic, 30 day retail; 90 day mail. Certain preventive medications (including contraceptives) are covered at No Charge.</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>Retail: $25 Copay Mail Order: $50 Copay</td>
<td>Retail: Not Covered</td>
<td>Single-source brand, 30 day retail; 90 day mail</td>
</tr>
<tr>
<td>Non-Preferred Drugs</td>
<td>Retail: $45 Copay Mail Order: $90 Copay</td>
<td>Retail: Not Covered</td>
<td>Multi-source brand, 30 day retail; 90 day mail</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</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>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Non-Emergency transportation not covered, except for medical necessity. Non-network pre-authorization required for non-emergency transportation or $500 penalty.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$30 Copay/visit</td>
<td>$30 Copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Non-network pre-authorization required or $500 penalty.</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>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out of Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$30 Copay/visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$30 Copay/initial visit only</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30 Copay/visit</td>
<td>40% Coinsurance</td>
</tr>
</tbody>
</table>

Employee Assistance Program (EAP) up to 3 sessions per subject 100%. Non-network pre-authorization required for certain intensive outpatient services or $500 penalty.
Neurobiological Disorders - Non-network pre-authorization is also required for benefits provided for Applied Behavioral Analysis (ABA) or $500 penalty.
Routine pre-natal care is covered at No Charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-network pre-authorization required for stays over 48 hours normal or 96 hours cesarean or $500 penalty.
Home health care 200 visits, private duty nursing $5,000/ calendar year combined in-network/out of network. One visit equals four hours of Skilled Care services. Non-network pre-authorization required or $500 penalty.
Physical, Occupational combined 60 visits/calendar year. Cardiac, Cognitive, Pulmonary, Speech 60 visits each/calendar year. Combined in-network/out of network.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong></td>
<td><strong>Out of Network Provider</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>120 days/ calendar year combined in-network/out of network. Non-network pre-authorization required or $500 penalty.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% Coinsurance</td>
<td>40% Coinsurance</td>
<td>6 months/lifetime combined in-network/out of network. Non-network pre-authorization required for Inpatient or $500 penalty.</td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$10 Copay/visit</td>
<td>$10 Copay/visit</td>
<td>Adult/child under 19: $10 copay/visit. Limit 1 exam per 12 months.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No Charge</td>
<td>No Charge</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. Adults max: $20 single, $30 bifocal, $40 trifocal, $75 lenticular, $75 contacts, $30 frames. Limit 1 per 24 months.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### 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.):**

- Cosmetic Surgery
- Dental Care Adult & Child
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- 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
- Infertility treatment
• Adult routine vision exam (i.e. refraction)
• Hearing aids
• Private-duty nursing
• Bariatric Surgery

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 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 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 at'ohwol ninisingo, kwijjigo holne' 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in network care of a well controlled condition)</th>
<th>Mia’s Simple Fracture (in network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$400</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$1,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,240</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $60
- The total Peg would pay is $1,800

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**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$1,470</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$120</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,280</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $60
- The total Joe would pay is $1,470

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**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>$280</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$60</td>
</tr>
<tr>
<td>Copayments</td>
<td>$210</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $0
- The total Mia would pay is $280

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


**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 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.

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 Benefisyo 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 (Arabic)

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。
Summary of Benefits and Coverage (SBC)

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.

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'ígi, t'áá jíík'eh, bee ná'ahóó'ti'. T'áá shqodi Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'ë'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béeeyh bee hane'i biká'ígíi 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).