




Choice Plus Premier Plan

Coverage for: Family | Plan Type: PS1

 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, call 1-888-332-8885 or visit [welcometouhc.com](http://welcometouhc.com). 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network: <b>\$750</b> Individual / <b>\$1,500</b> Family Non-Network: <b>\$1,500</b> Individual / <b>\$3,000</b> Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Network: <b>\$2,150</b> Individual / <b>\$4,500</b> Family Non-Network: <b>\$4,500</b> Individual / <b>\$9,000</b> Family Per calendar year.	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.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>prenotification</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://myuhc.com">myuhc.com</a> or call 1-888-332-8885 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Virtual visits (Telehealth) - \$20 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> , <u>deductible</u> does not apply. No virtual coverage non- <u>network</u> . If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Specialist</u> visit	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> or <u>coinsurance</u> may apply e.g. surgery.
	<u>Preventive care/screening/Immunization</u>	No Charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	40% <u>coinsurance</u>	<u>Prenotification</u> is required non- <u>network</u> for certain services or a \$300 penalty applies.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prenotification</u> is required non- <u>network</u> or a \$300 penalty applies.

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://welcometouhc.com">welcometouhc.com</a>	Tier 1 – Your Lowest Cost Option	Retail: \$10 <u>copay, deductible</u> does not apply. Mail-Order: \$20 <u>copay, deductible</u> does not apply.	Retail: \$10 <u>copay, deductible</u> does not apply.	<u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a requirement or may result in a higher cost. If you use a non- <u>network</u> pharmacy <u>prenotification</u> (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Certain preventive medications are covered at No Charge. Contraceptives are not covered. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Tier 2 – Your Mid-Range Cost Option	Retail: \$35 <u>copay, deductible</u> does not apply. Mail-Order: \$70 <u>copay, deductible</u> does not apply.	Retail: \$35 <u>copay, deductible</u> does not apply.	
	Tier 3 – Your Mid-Range Cost Option	Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply.	Retail: \$50 <u>copay, deductible</u> does not apply.	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prenotification</u> is required non- <u>network</u> for certain services or a \$300 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$150 <u>copay</u> per visit, <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	*20% <u>coinsurance</u>	* <u>Network deductible</u> applies
	<u>Urgent care</u>	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	\$50 <u>copay</u> per visit, <u>deductible</u> does not apply.	If you receive services in addition to <u>Urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prenotification</u> is required non- <u>network</u> or a \$300 penalty applies.

\* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Prenotification</u> is required <u>non-network</u> for certain services or a \$300 penalty applies.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prenotification</u> is required <u>non-network</u> or a \$300 penalty applies.
<b>If you are pregnant</b>	Office visits	No Charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Inpatient <u>prenotification</u> applies <u>non-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or a \$300 penalty applies.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per calendar year. <u>Prenotification</u> is required <u>non-network</u> or a \$300 penalty applies.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Outpatient rehabilitation services are unlimited per calendar year. <u>Prenotification</u> required <u>non-network</u> for certain services or a \$300 penalty applies.
	<u>Habilitative services</u>	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	Services are provided under <u>Rehabilitation Services</u> above. <u>Prenotification</u> required <u>non-network</u> for certain services or a \$300 penalty applies.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prenotification</u> is required <u>non-network</u> or a \$300 penalty applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Covers 1 per type of DME (including repair/replacement) every 3 years. <u>Prenotification</u> is required <u>non-network</u> for DME over \$1,000 or a \$300 penalty applies.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 360 days per lifetime. <u>Prenotification</u> is required <u>non-network</u> before admission for an Inpatient Stay in a hospice facility or a \$300 penalty applies.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 <u>copay</u> per visit, <u>deductible</u> does not apply.	40% <u>coinsurance</u>	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 the plan or policy document at [welcometouhc.com](http://welcometouhc.com).

## 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**.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Routine foot care – Except as covered for Diabetes
- Weight loss programs

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

- Bariatric surgery
- Chiropractic (Manipulative care) - \$1,000 per calendar year
- Hearing aids - \$5,000 per calendar year
- Private duty nursing
- Routine eye care (adult) - 1 exam per year

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

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information 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: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://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 1-888-332-8885.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-332-8885.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-332-8885.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-332-8885.

————— *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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)		<b>Managing Joe's type 2 Diabetes</b> (a year of routine in-network care of a well-controlled condition)		<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)	
■ <b>The plan's overall deductible</b>	\$750	■ <b>The plan's overall deductible</b>	\$750	■ <b>The plan's overall deductible</b>	\$750
■ <b>Specialist copay</b>	\$20	■ <b>Specialist copay</b>	\$20	■ <b>Specialist copay</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	20%	■ <b>Hospital (facility) coinsurance</b>	20%	■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other coinsurance</b>	20%	■ <b>Other coinsurance</b>	20%	■ <b>Other coinsurance</b>	20%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b> <i>Cost Sharing</i>		<b>In this example, Joe would pay:</b> <i>Cost Sharing</i>		<b>In this example, Mia would pay:</b> <i>Cost Sharing</i>	
<u>Deductibles</u>	\$750	<u>Deductibles</u>	\$375	<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0	<u>Copayments</u>	\$1,200	<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,200	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$80
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$30	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,010</b>	<b>The total Joe would pay is</b>	<b>\$1,605</b>	<b>The total Mia would pay is</b>	<b>\$1,130</b>

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](mailto: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.

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**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.

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PAUNA\VA: 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 Coverageo SBC).

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ATANSYON: Si w pale **Kreyol ayisyen (Haitian Creole)**, ou kapab benefisyé sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwotek syon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (F rench)**, de s services d'aide linguistique vous soot proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jezeli m6,visz po **polsku (Polish)**, udost pnilismy darmowe uslugi tlumacza. Prosimy zadzwonic pod bezplatny numer podany w niniejszym Zes ta,vieniu s,viadczen i refunda cji (Summary of Benefits and Coverage, SBC).

ATEN<;AO: Se voce fala **portugues (Portuguese)**, contate o servic;o de ass isten cia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia **italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate ii numero verde indicato all'intemo 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 Verfung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenuhemahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

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C EEB T OO M : Yo g k o j h ais Lus **Hmoob (Hmong)**, muaj ke v pab txh ais !us pub dawb rau koj. Th ov hu rau tus xov too j hu dawb tee v mua j n yob nta wm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

CH1..mUH'I! M: IU^JS\i'l'S UJ1Wm fiJi i 1 (K h mer) 1n.1n a w m fiJ1lthW'l'l'l l'li rl1:fISM1UIJl'l'l \Jl:!!tinJ ls11CU8 i'l'l'ilti[!]i iclCU1:fIS'l'rilITTTQll 1 fl.106 n.11vUH ll.JlUflclS Sll m fnu61l:l (Summary of Benefits and Coverage, SBC)12:'1

PAKD AAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaanpara kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti unegna daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dff BAA'A.K ONINIZIN **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. T'aa shqqdi Naaltsos Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii bee hodiilnih.

OGO\W: Haddii aadku 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).