



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/WGU (access code WGU2025), Surest mobile app or call 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://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 plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://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> : \$3,000 individual / \$6,000 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/WGU (access code WGU2025) or call 1-866-683-6440 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.
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 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*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$10 - \$65 <u>copay/visit</u>	\$195 <u>copay/visit</u>	Certain procedures performed in the office may have a higher office visit <u>copay</u> . <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>Specialist</u> visit	\$10 - \$65 <u>copay/visit</u>	\$195 <u>copay/visit</u>	
	<u>Preventive care/screening/immunization</u>	No charge	\$100 <u>copay/visit</u>	You may have to pay for services that are not <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.
If you have a test	Routine <u>diagnostic test</u> (e.g., x-ray, blood work) Non-routine <u>diagnostic test</u> (e.g., sleep study, genetic testing)	Routine <u>diagnostic test</u> : No charge Non-routine <u>diagnostic test</u> : \$10 - \$675 <u>copay/visit</u>	Routine <u>diagnostic test</u> : No charge Non-routine <u>diagnostic test</u> : Up to \$2,025 <u>copay/visit</u>	<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>Prior authorization</u> is required for certain Non-routine <u>diagnostic tests</u> or there may be no coverage.
	Imaging (CT/PET scans, MRIs)	\$75 - \$550 <u>copay/visit</u>	Up to \$1,500 <u>copay/visit</u>	<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>Prior authorization</u> is required for certain imaging tests or there may be no coverage.

*For more information about limitations and exceptions, see the plan or policy document at [Join.Surest.com/WGU](https://www.join.surest.com/WGU) (access code WGU2025).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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</p> <p>More information about <u>prescription drug coverage</u> is available at Caremark.com.</p>	Tier 1 drugs	30-Day Supply \$10 <u>copay</u> 90-Day Supply \$20 <u>copay</u>	30-Day Supply 60% <u>coinsurance</u> 90-Day Supply Not covered	<p>Certain Tier 1 drugs are available with no charge, including prescribed generic contraceptives and tobacco cessation medications.</p> <p>To learn more about drug tiers and about <u>copays</u> for specific drugs, visit Caremark.com website.</p> <p><u>Prior authorization</u> is required for certain drugs or there may be no coverage.</p>
	Tier 2 drugs	30-Day Supply \$40 <u>copay</u> 90-Day Supply \$80 <u>copay</u>	30-Day Supply 60% <u>coinsurance</u> 90-Day Supply Not covered	
	Tier 3 drugs	30-Day Supply \$80 <u>copay</u> 90-Day Supply \$160 <u>copay</u>	30-Day Supply 60% <u>coinsurance</u> 90-Day Supply Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-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)	\$15 - \$2,500 <u>copay/visit</u>	Up to \$7,000 <u>copay/visit</u>	<p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned copays within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain outpatient surgery 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>	\$375 <u>copay/visit</u>	\$375 <u>copay/visit</u>	<p><u>Copay</u> is waived if admitted within 24 hours. <u>Out-of-network emergency room care visit copay</u> applies to the <u>in-network out-of-pocket limit</u>.</p>
	<u>Emergency medical transportation</u>	\$225 <u>copay/transport</u>	\$225 <u>copay/transport</u>	<p><u>Prior authorization</u> is required for non-emergency medical transportation or there may be no coverage. <u>Out-of-network emergency medical transportation copay</u> applies to the in-network <u>out-of-pocket limit</u>.</p>
	<u>Urgent care</u>	\$35 <u>copay/visit</u>	\$105 <u>copay/visit</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 - \$2,500 <u>copay/stay</u>	Up to \$7,000 <u>copay/stay</u>	<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.</p> <p><u>Prior authorization</u> is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p>
	Physician/surgeon fees	No charge	No charge	

*For more information about limitations and exceptions, see the plan or policy document at [Join.Surest.com/WGU](https://www.surest.com/WGU) (access code WGU2025).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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: \$10 <u>copay/visit</u> Outpatient Facility: \$75 <u>copay/visit</u>	Home/Office: \$100 <u>copay/visit</u> Outpatient Facility: \$225 <u>copay/visit</u>	Certain procedures/services in the outpatient setting may have a lower <u>copay</u> . <u>Prior authorization</u> is required for certain outpatient services or there may be no coverage.
	Inpatient services	\$1,600 <u>copay/stay</u>	\$4,800 <u>copay/stay</u>	Certain procedures/services in the inpatient setting may have a lower <u>copay</u> . <u>Prior authorization</u> is required for certain inpatient services or there may be no coverage.
If you are pregnant	Office visits	No charge	\$100 <u>copay/visit</u>	<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. <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>Prior authorization</u> is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage.
	Childbirth/delivery facility services	\$625 - \$1,600 <u>copay/stay</u>	\$4,800 <u>copay/stay</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-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>	\$35 <u>copay</u> /visit	\$105 <u>copay</u> /visit	No visit limit - combination of <u>network providers</u> and <u>out-of-network providers</u> per person per calendar year. <u>Prior authorization</u> is required for certain <u>home health care</u> services or there may be no coverage.
	<u>Rehabilitation services</u>	\$5 - \$85 <u>copay</u> /visit	Up to \$215 <u>copay</u> /visit	Physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation and aural rehabilitation: combined limit 40 visits per calendar year. Visit limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per calendar year.
	<u>Habilitation services</u>	\$5 - \$85 <u>copay</u> /visit	Up to \$215 <u>copay</u> /visit	<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>Skilled nursing care</u>	\$1,200 <u>copay</u> /stay	\$3,600 <u>copay</u> /stay	60 visit limit per person per calendar year. <u>Prior authorization</u> is required 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/WGU (access code WGU2025) website. <u>Prior authorization</u> is required for certain <u>DME</u> or there may be no coverage.
	<u>Hospice services</u>	Home: \$35 <u>copay</u> /visit Inpatient: \$1,600 <u>copay</u> /stay	Home: \$105 <u>copay</u> /visit Inpatient: \$4,800 <u>copay</u> /stay	None
If your child needs dental or eye care	Children's eye exam	No charge	\$100 <u>copay</u> /visit	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at Join.Surest.com/WGU (access code WGU2025).

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.)

- 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 (20 visit limit per person per calendar year)
- Bariatric surgery (limited to one surgery per lifetime)
- Chiropractic care (20 visit limit per person per calendar year)
- Hearing aids
- Routine eye care (Adult) (limited to one exam per person per calendar 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 those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. 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 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-866-683-6440.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-683-6440.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-683-6440.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-683-6440.

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)

- The plan's overall deductible \$0
- Specialist copayment \$10 - \$65
- Hospital (facility) copayment \$150 - \$2,500
- Other coinsurance \$0

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 \$12,700

In this example, Peg would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is \$660

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

- The plan's overall deductible \$0
- Specialist copayment \$10 - \$65
- Hospital (facility) copayment \$150 - \$2,500
- Other coinsurance \$0

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

In this example, Joe would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is \$1,620

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

- The plan's overall deductible \$0
- Specialist copayment \$10 - \$65
- Hospital (facility) copayment \$150 - \$2,500
- Other coinsurance \$0

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$1,000

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.

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PAUNA\VA:Kungnagsasalita 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).

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ATANSYON:Si wpale **Kreyol ayisyen (Haitian Creole)**, ou kapab benefisyè sevis ki gratis pou ede w nan lang paw. 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).

IJ,VAGA:Jezeli m6,visz po **polsku (Polish)**, udost pnilismy darmowe uslugi tlumacza. Prosimy zadzwonic pod bezplatny numer podany w niniejszym Zesta,vieniu s,viadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;AO:Se voce fala **portugues (Portuguese)**, contate o servico de assistencia 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 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 Kostenumnahmen(Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

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Coverage, SBC)12:'1

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti bad dang 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 dayt.oynga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

Dfi BAA'AKONINIZIN:Dine(Navajo) bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. Tai 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.

OGOW: Haddii aad k.71 hadasho Soomaaji (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).