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 1-800-382-4259 or visit 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/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	SLUCare & SSM Network: **$400** Individual / **$800** Family Other Participating Provider Network: **$1,000** Individual / **$2,000** Family. Non-Network: **$3,000** Individual / **$6,000** Family. Per calendar year.	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 a 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	SLUCare & SSM Network: **$2,500** Individual / **$5,000** Family. Other Participating Provider Network: **$3,050** Individual / **$6,100** Family. Non-Network: **$8,000** Individual/ **$16,000** Family. Per calendar year.	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, the overall family out-of-pocket limit must be met before the out-of-pocket limit is satisfied.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-800-382-4259** 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.

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
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	Virtual visits (Telehealth) - $10 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage non-network If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	$20 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network for certain services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required for U.S. non-network benefits.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition	Rx out-of-pocket limit	$1,500 Individual / $3,000 Family.			Prescription drug coverage is available through Express Scripts. Preventive Medications are priced according to tier. Maintenance Medications are required to be filled at 90 Day Supply through Express Scripts Mail Order or Walgreens.
	Member Cost Share	Retail (34 Day Supply)		Mail Order (90 Day Supply)	
	Tier 1 – Your Lowest Cost Option	$10		$25	
	Tier 2 – Your Mid-Range Cost Option	25% coinsurance $30 min - $50 max		25% coinsurance $75 min - $125 max	
	Tier 3 – Your Mid-Range Cost Option	50% coinsurance $50 min - $100 max		50% coinsurance $125 min - $250 max	
	Tier 4 – Your Highest Cost Option	20% up to $200 max		N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network for certain services.
	Physician/surgeon fees	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	$250 copay per visit, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	*20% coinsurance	*Network deductible applies
	Urgent care	$60 copay per visit, deductible does not apply	$60 copay per visit, deductible does not apply	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Non-Network Provider (You will pay the most)	
					Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based-services.
	Physician/surgeon fees	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network for certain services. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based services.
	Inpatient services	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based services.
If you are pregnant	Office visits	No Charge	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service a copayment,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	40% coinsurance	Inpatient Preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	40% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required non-network.
	Rehabilitation services	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	Limits per calendar year: Physical/Occupational/ Speech and Pulmonary: combined limit 60 visits; Cardiac: 36 visits. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based services.
	Habilitative services	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SLU Care & SSM Network Provider (You will pay the least)	Other Participating Provider Network Provider (You may pay more)	Non-Network Provider (You will pay the most)	
	Skilled nursing care	10% coinsurance	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required non-network. Following services are not covered: Health care services from an out-of-Network provider, for non-emergent, subacute inpatient or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient/outpatient Rehabilitation Facility and Skilled Nursing Facility. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance. Out of network services would be available for acute hospital-based care and outpatient, office based services.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network for DME over $1,000.
	Hospice services	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit, deductible does not apply	20% coinsurance	40% coinsurance	Network refractive eye examinations are covered and limited to one exam every other calendar year.
	Children's glasses	Not Covered	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	No coverage for Children's Dental check-up.

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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care
- 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) – 26 visits per calendar 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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 or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact 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 1-800-382-4259.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-4259.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-382-4259.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-382-4259.

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	$400
Specialist copay	$20
Hospital (facility) coinsurance	10%
Other copay	$10

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:

Cost Sharing	
Deductibles	$400
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,530**

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

The plan's overall deductible	$400
Specialist copay	$20
Hospital (facility) coinsurance	10%
Other copay	$10

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:

Cost Sharing	
Deductibles	$400
Copayments	$120
Coinsurance	$685
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,285**

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

The plan's overall deductible	$400
Specialist copay	$20
Hospital (facility) coinsurance	10%
Other copay	$10

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:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

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

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

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。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí 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).