SOUTHERN TRUST COMPANY
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UnitedHealthcare

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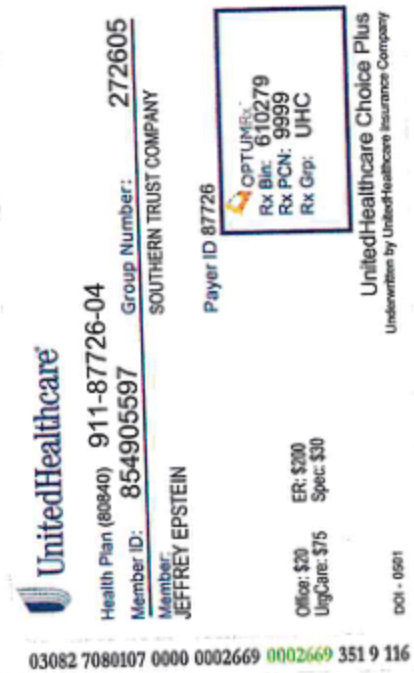

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Thank you for being a UnitedHealthcare member! We are proud to serve you.

Your UnitedHealthcare health plan identification (ID) card is attached. Please check your card to be sure all information is correct. If not, please let us know by calling the member number on the card. You may begin using your card on your effective date. Remember to take your ID card to your appointments and have it ready if you call us with questions.

Sign up for myuhc.com® and download the UnitedHealthcare Health4Me® mobile app to find tools and information to help you manage your health and benefits at home and on the go. You can find network doctors, track and pay claims, estimate costs, and more. You can even view, download or print a copy of your ID card.

We're here to help. If you have questions, visit myuhc.com or call the toll-free member phone number on your ID card. TTY users can dial 711.

Gracias por elegir UnitedHealthcare

Con su nueva tarjeta de identificación médica de miembro de UnitedHealthcare, usted tiene acceso a servicios que pueden ayudarle a llevar una vida más saludable.

Su nueva tarjeta de identificación está diseñada para proporcionarle una mejor experiencia como miembro, facilitando su lectura y transferencia de información. Puede comenzar a usar esta nueva tarjeta inmediatamente el día de entrada en vigencia de su cobertura o después.

This card is for identification only. It is not proof of membership and it does not guarantee coverage.

Printed: 12/17/16

Members: We're here to help. Check benefits, view claims, find a doctor, ask a question and more.

Web:	www.myuhc.com	Call anytime to speak with a Nurse
Email:	Advocate4me@uhc.com	
Phone:	800-782-3740	
Mental Health:	800-842-2065	

Providers: 877-842-3210 or www.UnitedHealthcareOnline.com
Medical Claims: P.O. BOX 740800 ATLANTA GA 303740800
PR - MAPFRE - PO Box70297, San Juan, PR 00936-8297

MAPFRE MultiPlan

Pharmacists: 888-290-5416
Pharmacy Claims: OptumRx PO Box 29044 Hot Springs, AR 71903

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UnitedHealthcare®
A UnitedHealth Group Company

UnitedHealthcare
185 Asylum Street
Cityplace I
Hartford, CT 06103

December 14, 2016

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SOUTHERN TRUST COMPANY
6100 RED HOOK QUARTER, B-3
ST THOMAS, VI 008020000

Dear Customer:

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). The SBC provides you information to better understand your plan and allows you to compare coverage options.

You are receiving this package due to one of the following plan coverage events that requires you to receive an SBC.

- Upon application for coverage,
- Prior to any material modification of your plan coverage,
- Prior to your plan renewal, or
- You are a special enrollee.

If you are an Employer, you can find your group's SBC documents by logging into www.employereservices.com and select "Summary of Benefits and Coverage" under the Resources menu.

For more information regarding this document, please visit uhc.com/summary or contact the Member Services number on the back of your ID card.

Very truly yours,

Christopher Hock
Broker & Employer Operations
UnitedHealthcare

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com** or by calling **1-800-782-3740.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$0** Non-Network: **$500** Indiv **/ $1,000** Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Network: **$2,500** Indiv **/ $5,000** Family Non-Network: **$5,000** Indiv **/ $10,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain Pre-Notification for services , copays and prescription drugs.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	20% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	20% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per policy period. Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Preventive care/screening/immunization	No Charge	Not Covered	No coverage non-Network. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins, after ded	None
	Imaging (CT/PET scans, MRIs)	$200 copay per service	20% co-ins, after ded	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouh-c.com.	Tier 1 - Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $25 copay	Retail: $10 copay	Provider 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 specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge. Growth Hormone Therapy : 30% co-ins, ded does not apply.
	Tier 2 - Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $75 copay	Retail: $30 copay	
	Tier 3 - Your Highest-Cost Option	Retail: $50 copay Mail-Order: $125 copay	Retail: $50 copay	
	Tier 4 (if applicable) - Additional High-Cost Options	Not applicable	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% co-ins, after ded	$250 outpatient surgery per occurrence deductible applies prior to the Annual Deductible.
	Physician/surgeon fees	No Charge	20% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$200 copay per visit	$200 copay per visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$75 copay per visit	20% co-ins, after ded	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-ins, after ded	Pre-Notification required for non-network or benefit reduces to 50% of allowed. $500 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	No Charge	20% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit	20% co-ins, after ded	Limited to 20 visits per policy period (combined with Outpatient Substance use). Pre-Notification required for certain services for non-network or benefit reduces to 50% of allowed.
	Mental/Behavioral health inpatient services	No Charge	20% co-ins, after ded	Limited to 30 days per policy period (combined with Inpatient Substance use). Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Substance use disorder outpatient services	$30 copay per visit	20% co-ins, after ded	Limited to 20 visits per policy period (combined with Outpatient Mental health). Pre-Notification required for certain services for non-network or benefit reduces to 50% of allowed.
	Substance use disorder inpatient services	No Charge	20% co-ins, after ded	Limited to 30 days per policy period (combined with Inpatient Mental health). Pre-Notification required for non-network or benefit reduces to 50% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-ins, after ded	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	No Charge	20% co-ins, after ded	Inpatient Notification may apply. $500 Inpatient Stay per occurrence deductible applies prior to the Annual Deductible.
If you need help recovering or have other special health needs	Home health care	No Charge	20% co-ins, after ded	Limited to 60 visits per policy period. Pre-Notification required for non-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$20 copay per outpatient visit	20% co-ins, after ded	Depending on the type of therapy, there is a limit of 20-36 visits per policy period.
	Habilitative services	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	No Charge	20% co-ins, after ded	Limited to 60 days per policy period (combined with Inpatient Rehabilitation). Pre-Notification required for non-network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	No Charge	20% co-ins, after ded	Covers 1 per type of DME (including repair/replace) every 3 years. Pre-Notification required for non-network DME over $1000 or no coverage.
	Hospice service	No Charge	20% co-ins, after ded	Inpatient Pre-Notification required for non-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not Covered	Limited to 1 exam every 2 years. No coverage non-Network.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Habilitation services
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the United States Virgin Islands Division of Banking and Insurance at 340-774-7166 or

www.ltg.gov.vi/division-of-banking-and-insurance.html. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Virgin Islands Division of Banking and Insurance at 340-773-6459 or visit www.ltg.gov.vi.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3740

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,320
- **Patient pays** $220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,260
- **Patient pays** $1,140

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,140**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No** . Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No** . Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes** . When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-782-3740** or visit us at **www.welcometouhc.com.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

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 به طور 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: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្តារ 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).