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 1-877-280-2964 or visit us at https://globalhealth.com/media/4153/cert_lggrp_plat_ok_2020_clean.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.GlobalHealth.com/media/2711/2017_uniformglossary.pdf or call 1-877-280-2964 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered before you meet a deductible.	This plan covers some items and services even if you haven't yet met the 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 preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$3,000/individual or $6,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and healthcare this plan doesn't cover.	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 www.GlobalHealth.com or call 1-877-280-2964 for a list of network providers.	This plan uses a provider network. You will pay the least if you use a provider in the Preferred Facility network. You pay more if you use a provider in the Non-preferred Facility 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	No charge.	Not covered	None.
	Specialist visit	$50 copayment/visit. Chiropractic care: $25 copayment/visit. Foot care: $20 copayment/visit.	Not covered	Except for obstetrician/gynecologist and chiropractic care, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Preventive care/screening/ immunization	No charge.	Not covered	*See Preventive Care Benefits in this plan's Member Handbook for details. 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)	No charge.	Not covered	None.
	Imaging (CT/PET scans, MRIs)	PCP (primary care physician) visit: No charge. Specialist visit: No charge. Preferred facility: $250 copayment/scan. Non-preferred facility: $750 copayment/scan.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Included in specialist visit copayment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.GlobalHealth.com	Generic drugs (Tier 1)	30-day supply – No charge, low-cost generic. $15 copayment/prescription, preferred generic. 90-day supply – No charge, low-cost generic. $30 copayment/prescription, preferred generic.	Not covered	A 30-day supply is through retail. a 90-day supply may be through retail or mail order.
	Preferred brand drugs (Tier 2)	30-day supply – $60 copayment/prescription. 90-day supply – $120 copayment/prescription.	Not covered	Preauthorization and some restrictions may apply. *See Prescription Drug Benefits in this plan's Member Handbook for details. Otherwise, you will have to pay the entire cost of the
	Non-formulary drugs (Tier 3)	30-day supply – $90 copayment/prescription. 90-day supply – $180	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		copayment/prescription.		services. A 30-day supply is through retail. a 90-day supply may be through retail or mail order. Specialty drugs are only available in 30-day supplies.
	Specialty drugs (Tier 4)	Preferred specialty – 15% coinsurance up to $400 copayment. Non-preferred specialty – 15% coinsurance up to $600 copayment. Oral chemotherapy drugs – 15% coinsurance up to $100 copayment.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred facility: $250 copayment/visit. Non-preferred facility: $750 copayment/visit.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Physician/surgeon fees included in facility fee.
	Physician/surgeon fees	No charge.	Not covered	
If you need immediate medical attention	Emergency room care	$300 copayment/visit.	$300 copayment/visit.	Limited to services within the United States. Emergency room copayment waived if admitted to the hospital.
	Emergency medical transportation	$100 copayment/occurrence.	$100 copayment/ occurrence.	
	Urgent care	$15 copayment/visit.	$15 copayment/visit.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copayment/day up to $1,500 copayment/stay.	Not covered	Referral and preauthorization required, except for emergency care or childbirth. Otherwise, you will have to pay the entire cost of the services. Physician/surgeon fees included in facility fee.
	Physician/surgeon fees	No charge.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge. Intensive outpatient program: No charge. Partial hospitalization program: No charge.	Not covered	Other than office visits, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Inpatient services	Residential treatment center: $75 copayment/day – Inpatient hospital facility: $300 copayment/day up to $1,500 copayment/stay.	Not covered	
If you are pregnant	Office visits	No charge / prenatal and postnatal care.	Not covered	Cost sharing does not apply for preventive services. Childbirth/delivery professional services included in facility
	Childbirth/delivery professional services	No charge.	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$500 copayment/stay.	Not covered	services.
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. 30 visit limit per plan year.
	Rehabilitation services	Inpatient: No charge. Office visit: $25 copayment/visit. Rehabilitation outpatient facility: $50 copayment/day. Rehabilitation inpatient facility: $200 copayment /day.	Not covered	Referral and preauthorization required except for physical therapy evaluation. Otherwise, you will have to pay the entire cost of the services. Outpatient and rehabilitation facilities: 30 visit limit per plan year. Inpatient services included in hospital facility fee.
	Habilitation services	Inpatient: No charge. Office visit: $25 copayment/visit. Habilitation outpatient facility: $50 copayment/day.	Not covered	Referral and preauthorization required except for physical therapy evaluation. Otherwise, you will have to pay the entire cost of the services. Inpatient services included in hospital facility fee. Limited to the following diagnoses: • Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome; • Childhood disintegrative disorder – Heller's syndrome; • Rett's syndrome; and • Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood.
	Skilled nursing care	$75 copayment/day.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Skilled nursing: 30-day limit per plan year.
	Durable medical equipment	20% coinsurance.	Not covered	
	Hospice services	No charge.	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$30 copayment/visit.	Not covered	One exam limit per plan year.
	Children's glasses	No charge.	Not covered	Limited to one pair of basic frames and lenses or first set of contact lenses following cataract surgery.
	Children's dental check-up	Not covered.	Not covered	No coverage.

* For more information about limitations and exceptions, see the plan or policy document at www.GlobalHealth.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
- Bariatric surgery
- Dental care (Adult)
- Dental care (Children's dental check-up)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Chiropractic care
- Cosmetic surgery (Repair of conditions resulting from accidental injury or congenital defects, when medically necessary. See Member Handbook for limitations.)
- Hearing aids (Limited to one aid per ear every 48 months.)
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care (Covered for diabetics only.)
- Weight loss programs (Covered only if provided by network providers.)

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 U.S. Department of Labor, Employees Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or you may contact GlobalHealth at 1-877-280-2964 or www.GlobalHealth.com. 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: GlobalHealth Customer Care at 1-877-280-2964 or visit www.GlobalHealth.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or the Oklahoma Insurance Department 1-800-522-0071 or (405) 521-2991 (in-state only) http://www.ok.gov/oid/Consumers.

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 1-877-280-2964 (TTY: 711).

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	$50
Hospital (facility) copayment	$500
Other copayment	$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$510**

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	$50
Hospital (facility) copayment	$300/day up To $1,500/stay
Other coinsurance	20%

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	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,630**

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$300/day up To $1,500/stay
Other coinsurance	20%

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

Notice about non-discrimination

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-877-280-2964 (toll-free).

If you believe that GlobalHealth, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Attn: Executive Director, Compliance and Legal Services, 210 Park Ave, Ste 2800, Oklahoma City, OK 73102-5621, Fax: (405) 280-5894, or E-mail: compliance@globalhealth.com.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language	Translation
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de GlobalHealth. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-877-280-2964.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình GlobalHealth. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-877-280-2964.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入SBM項目的名稱 GlobalHealth 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康

Language	Translation
	保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-877-280-2964.
Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 GlobalHealth을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-877-280-2964 로 전화하십시오.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch GlobalHealth. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-877-280-2964.
Arabic	الهامة التواريخ عن ابحث .) GlobalHealth (خلال من التغطية على للحصول طلبك بخصوص مهمة معلومات الاشعار هذا يحوي .هامة معلومات الاشعار هذا يحوي دفع في للمساعدة او الصحية تغطيتك على للحفاظ معينة تواريخ في اجراء لاتخاذ تحتاج قد .الاشعار هذا في 1-877-280-2964 (ب اتصل .تكلفة أي دون من بلغتك والمساعدة المعلومات على الحصور في الحق لك .التكاليف
Burmese	ဤစာ၌ ေအရးႀကီးေ သာ အြ်ကအလက ပါ၀ငပါသည ။ ဤစာ၌ သင ၏ေ လ ်ာကလႊ ာ သသု႔မဟုတ္ GlobalHealth c သက္သုိင ေ သာ သင ႃ႔ံစီးခြင အြ်ကအလကမ်ား ပါ၀ငပါသည ။ အေသကရကစဲ ကသု ဤစာ၌ရ ာေ ခဖပါ။ သတ္မွတ္ုာ်ိးေ သာ ေ နာက္ံ ု ိးရက မတ္သုငမီ က်န ိးမာေ ရး႐ႃ႔ံစီးခြင သသု႔မဟုတ္ စရသတ္မွ႐ႃ႔ံစီးခြင ဆကလကရရ သေ ေနစရန ေ ဆာင႐ြရကစရာရ သသည္သုိ႔ကသု ေ ဆာင႐ြရကပါ။ ဤကသစာ c ပတ္ုက ၍ မ န္ကုန ေ သာအြ်ကအလကမ်ားရရ သရန ကုန္က်စရသတ္ ေ ပီးရန္မလသုဘဲ မသမသဘာသာစကား ဖင အကူအညီရယူ သ ူ္ငြ ။ 1-877-280-2964။
Hmong	**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm GlobalHealth. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-877-280-2964.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng GlobalHealth. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-877-280-2964.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de GlobalHealth. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l’aide dans votre langue à aucun coût. Appelez 1-877-280-2964.
Laotian	ການແຈ້ງການນ ້ມ ຂໍ້ມູນສໍາຄັນ. ການແຈ້ງການນ ້ມ ຂໍ້ມູນທ ່ສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກຫ ຼືການຄ

Language	Translation
	້ມຄອງຂອງທ່ານໂດຍຜ່ານ GlobalHealth. ເບິ່ງສໍາລັບກໍານົດວັນທ ່ສໍາຄັນໃນແຈ້ງການນ ້. ທ່ານອາດຈໍາເປັນຕ້ອງໃຊ້ເວລາດໍາເນ ນການໂດຍກໍານົດເວລາທ ່ແນ່ນອນ ຈະຮັກສາການຄ ້ມຄອງສ ຂະພາບຂອງທ່ານຫ ຼືການຊ່ວຍເຫ ຼືອທ ່ມ ຄ່າໃຊ້ຈ່າຍ. ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນ ້ແລະການຊ່ວຍເຫ ຼືອໃນພາສາຂອງທ່ານທ ່ບ່ມ ຄ່າໃຊ້ຈ່າຍ. ໂທ 1-877-280-2964.
Thai	ประกาศนี้มีข้อมูลสาคัญ ประกาศนี้มีข้อมูลที่สาคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน GlobalHealth ดูกาหนดการในประกาศนี้ คุณอาจจะต้องดาเนินการภายในกาหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-877-280-2964
Urdu	معالومات اہم میں بارے کے خدمات اور درخواست کے اپ سے GlobalHealth میں اشتہار اس ہے۔ معالومات اہم میں اشتہار اس ملنے مدد مالی میں ادائگی کی اخراجات اور رکھنے برقرار کو خدمات کی صحت کی ہے سکتا ہو کریں۔ نظر کا تاریخوں اہم میں اشتہار ہے۔ کا کرنے حاصل معالومات اور مدد مفت میں زبان اپنی کو اپ گی۔ پڑے کرنی کارروائی کچھ پہلے سے لائن ڈیڈ یا تاریخ خاص کو اپ لیے، کے ہے۔ حق کریں۔ فون 1-877-280-2964
Cherokee	ᎤᏔᏍᏓᏁᏗ ᏕᏚᏃᏣᎢ ᎤᏐᏍᏍᏓᏁᏗ. ᎯᎠ ᎤᏔᏍᏓᏁᏗ ᎡᏣᏃᎯ4 ᏥᏣᏔᎵᏞᎢ ᎡᏣᏭᏍᏍᏙᏗ ᎤᏂᏍᎪᏔᎤ ᎯᏧᏂᏙᏱ ᎡᏣᏕ4ᏍᎤᏎᏓ GlobalHealth ᏕᏣᎾᏍᏍᏓᏁᏗᏏᎢ. ᏣᏚᎡᏍᏕᏍᏓᏁᏗ ᏓᏙᏓᏒ ᎯᎠ ᏕᏚᏃᏣᎢ. ᎡᎷᏣ ᎪᎱᏍᏓᏁᏗ ᏦᏄᎶᏩᏁᏗ ᎠᏧ ᏣᎤᏅᏓᏁᏗ ᏑᏂᎬᏔᏍᏓ ᏂᏂᎬᏃᏴ ᎢᏕ ᏥᏚᎪᏄᎾᏁᎢ. ᏙᎯ ᏣᏚᏁ ᎠᏂᎠᎤᏂᏍᏕ ᏣᏱ ᎠᏧ ᏧᎬᏩᎳᎤᎢ ᏆᏒ ᎤᏁᏣᏴᏍᏓᏁᏗ ᏂᏆᎡᎾ ᏩᏰᏴ. ᎠᏓᏍᏔᎳᎤᎤᏱ ᎠᏓᏍᏕᏔᏍᏓᏁᏗ ᎡᏣᏁᏗ ᏃᏧ ᎡᏣᏃᎯ4ᏁᎢ ᏣᏚᎵᏍᎬ ᏣᏕᏔᏂᎯᏍᏓᏁᏗᏍᏏ ᏣᏉᎵ ᏕᎤᏂᎯᏍᏓᏁᏗ ᎬᏁ ᏃᏧ ᏧᎬᏩᎳᏁᏗ ᏂᏆᎡᎾ ᏆᎡᎢ. ᏁᏔᏃᎯᏁ ᏗᏍᏓᏁᏗ ᎯᎠ 1-877-280-2964.
Persian	مهم های تاریخ به .{ GlobalHealth به مربوط شما ای بیمه پوشش یا و تقاضا فرم درباره مهم اطلاعات حامی اعلامیه این .میباشد مهم اطلاعات حامی اعلامیه این یا مزایای پوشش حفظ برای مشخصی های تاریخ به تا است ممکن شما .نمایید توجه اعلامیه این در رایگان طور به خود زبان به را کمک و اطلاعات این که دارید را این حق شما .باشید کارهایی انجام به ملزوم مزایای مخارج به کمک برای نمایید دریافت. 1-877-280-2964