










Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
 <p>Network coverage only You can usually save money when you receive care for covered health care services from network providers.</p>	<input type="checkbox"/>
 <p>Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.</p>	<input checked="" type="checkbox"/>
 <p>Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.</p>	<input type="checkbox"/>
 <p>Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.</p>	<input type="checkbox"/>
 <p>Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.</p>	<input checked="" type="checkbox"/>
 <p>Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.</p>	<input checked="" type="checkbox"/>
 <p>Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.</p>	<input type="checkbox"/>
 <p>Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.</p>	<input type="checkbox"/>
 <p>Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.</p>	<input checked="" type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$3,000	\$10,000
Family	\$6,000	\$20,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	\$3,000	\$20,000
Family	\$6,000	\$40,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care	No copay	30%*
<p><i>Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.</i></p> <p><i>Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.</i></p>		
Office Services - Sickness & Injury		
Primary Care Physician	No copay*	30%*
<p><i>Telehealth is covered at the same cost share as in the office.</i></p> <p><i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</i></p>		
Specialist	No copay*	30%*
<p><i>Telehealth is covered at the same cost share as in the office.</i></p> <p><i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</i></p>		
Urgent Care	No copay*	30%*
<p><i>Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.</i></p>		

*After the Annual Medical Deductible has been met.

*Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Virtual Care Services

No copay*

30%*

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Accidental Dental

No copay*

No copay*

Emergency Ambulance

No copay*

No copay*

Emergency Room¹

No copay*

No copay*

Limited to \$200 per visit for Non-Emergent Emergency Room Services.

Non-Emergency Ambulance¹

No copay*

30%*

Inpatient Care

Congenital Heart Disease Surgeries¹

No copay*

30%*

Hospital Inpatient Stays¹

No copay*

30%*

Inpatient Habilitative Services¹

The amount you pay is based on where the covered health care service is provided.

Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.

Skilled Nursing Facility & Inpatient Rehabilitation Facility Services¹

No copay*

30%*

Limited to 60 days per year in an Inpatient Rehabilitation Facility.

Limited to 30 days per Inpatient Stay in a Skilled Nursing Facility.

Outpatient Care

Habilitative Services

Manipulative treatment services

No copay*

30%*

Other habilitative services

No copay*

30%*

For outpatient therapies (physical therapy, occupational therapy, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.

Home Health Care¹

No copay*

30%*

Limited to 60 visits per year.

One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Lab Testing ¹	No copay*	30%*
<i>Limited to 18 Presumptive Drug Tests per year.</i>		
<i>Limited to 18 Definitive Drug Tests per year.</i>		
<i>For Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Benefits are not available for laboratory services received from a Network provider who is a non-Designated Diagnostic Provider.</i>		
Major Diagnostic and Imaging ¹	No copay*	30%*
Physician Fees for Surgical and Medical Services	No copay*	30%*
Rehabilitation Services		
Manipulative treatment services	No copay*	30%*
Other rehabilitation services	No copay*	30%*
<i>Limited to 20 visits of physical therapy per year.</i>		
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>		
<i>Limited to 20 visits of occupational therapy per year.</i>		
<i>Limited to 20 visits of cognitive rehabilitation therapy per year.</i>		
<i>Limited to 36 visits of cardiac rehabilitation therapy per year.</i>		
<i>Limited to 20 visits of speech therapy per year.</i>		
<i>Limited to 20 visits of pulmonary rehabilitation therapy per year.</i>		
<i>Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.</i>		
Scopic Procedures	No copay*	30%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>		
Surgery ¹	No copay*	30%*
Therapeutic Treatments ¹	No copay*	30%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>		
X-ray and other Diagnostic Testing ¹	No copay*	30%*
Supplies and Services		
Diabetes Self-Management Items ¹	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training ¹	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Durable Medical Equipment, Orthotics and Supplies ¹	No copay*	30%*
<i>Limited to a single purchase of a type of DME or orthotic every three years.</i>		
<i>Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. Benefits for insulin pumps are limited to one pump per year.</i>		
Enteral Nutrition	No copay*	30%*
Hearing Aids	No copay*	30%*
<i>Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>		
Ostomy Supplies	No copay*	30%*
Pharmaceutical Products	No copay*	30%*
<i>This includes medications given at a doctor's office, or in a covered person's home.</i>		
Prosthetic Devices ¹	No copay*	30%*
<i>Limited to a single purchase of each type of prosthetic device every three years.</i>		
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>		
Urinary Catheters	No copay*	30%*
Pregnancy		
Maternity Services ¹	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient ¹	No copay*	30%*
Outpatient and Transitional Care ¹	No copay*	30%*
Partial Hospitalization and Transitional Care ¹	No copay*	30%*
Other Services		
Autism Spectrum Disorder Services ¹	The amount you pay is based on where the covered health care service is provided.	
Cellular or Gene Therapy ¹	The amount you pay is based on where the covered health care service is provided.	
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>		
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.	
Dental/Anesthesia Services - Hospital Ambulatory Surgery Services ¹	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility ¹	No copay*	30%*
<i>Limited to \$20,000 per Covered Person per lifetime.</i>		
<i>Limited to \$5,000 for Prescription Drug Products per Covered Person.</i>		
<i>This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.</i>		
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care ¹	No copay*	30%*
Kidney Disease Treatment ¹	The amount you pay is based on where the covered health care service is provided.	
Preimplantation Genetic Testing (PGT) and Related Services ¹	No copay*	30%*
<i>Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.</i>		
<i>Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</i>		
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services ¹	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services	The amount you pay is based on where the covered health care service is provided.	Not covered
<i>Network Benefits must be received from a Designated Provider.</i>		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage
	In Network Out of Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Annual Deductible - Network and Out-of-Network

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	Out-of-Network Pharmacy	Mail Order Network Pharmacy**
Tier 1 \$	No Copay*	No Copay*	No Copay*
Tier 2 \$\$	No Copay*	No Copay*	No Copay*
Tier 3 \$\$\$	No Copay*	No Copay*	No Copay*

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.



Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Find a Doctor or Facility**.
- Choose **Search for a health plan**.
- Choose **Choice Plus** to view providers in the health plan's network.



Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to [welcometouhc.com](https://www.welcometouhc.com) > **Benefits** > **Pharmacy Benefits**.
- Select **Advantage** to view the medications that are covered under your plan.



Access your plan online.

With [myuhc.com](https://www.myuhc.com)®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Good stuff that's good to know.

I dig it!

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not apply to Prescription Drug Products that are prescribed by a Physician for the treatment of HIV infection, illness or medical condition arising from or related to HIV infection, if the medication is approved by the FDA and prescribed and administered in accordance with the treatment protocol approved for an Investigational new drug.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Drugs available over-the-counter.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Growth hormone therapy unless required by state law.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

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

If you think you weren't treated fairly 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, UT 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 phone number listed on your ID card, 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, 1-800-537-7697 (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 others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تويوغللا تددع اسما مل تامدخ ناف، (Arabic) ءيبرعل اشدحت تنك اذا :ءيبن ءل ع ءردملا ين اءملا فءءا مل مقرب ل اءءال اءءرؤ. ءل ءءاءءم ءءن اءملا ءءب ءءا ءل ءءاطب

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर काल 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódí ninaaltsoos nitl'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh 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 telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



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 www.welcometouhc.com or by calling 1-866-673-6293. 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?	Network: \$3,000 Individual / \$6,000 Family out-of-Network: \$10,000 Individual / \$20,000 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. <u>Preventive care</u> is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</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 deductible. See a list of covered <u>preventive services</u> 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?	Network: \$3,000 Individual / \$6,000 Family out-of-Network: \$20,000 Individual / \$40,000 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 plan, 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 out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	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 network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of <u>network providers</u> .	This plan uses a <u>provider Network</u> . You will pay less if you use a provider in the plan's Network. You will pay the most if you use an <u>out-of-Network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan 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 provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Virtual visits (Telehealth) - 0% <u>coinsurance</u> by a Designated Virtual <u>Network Provider</u> .
	<u>Specialist</u> visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	* 30% <u>coinsurance</u>	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. * <u>Deductible/coinsurance</u> may not apply to certain services.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of- <u>Network</u> for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com .	Tier 1 - Your Lowest-Cost Option	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: 90 day supply or *Preferred 90 Day Retail <u>Network</u> pharmacy. If you use an out-of- <u>Network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. 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. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 3 - Your Midrange-Cost Option	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services for out-of- <u>Network</u> or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Network partial <u>hospitalization</u> /intensive outpatient treatment: 0% <u>coinsurance</u> <u>Preauthorization</u> required for certain services for out-of- <u>Network</u> or benefit reduces to 50% of allowed.

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)	
	Inpatient services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>preauthorization</u> apply for out-of- <u>Network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits each; Cardiac: 36 visits.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Services provided under and limits are combined with <u>Rehabilitation services</u> above. Cost share applies for outpatient services only. <u>Preauthorization</u> required for out-of- <u>Network</u> inpatient services or benefit reduces to 50% of allowed.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Skilled nursing is limited to 30 days per calendar year. (Inpatient Rehabilitation and Habilitation limited to 60 days each). <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers 1 per type of <u>Durable medical equipment</u> (including repair/replace) every 3 years. <u>Preauthorization</u> required for out-of- <u>Network</u> <u>Durable medical equipment</u> over \$1,000 or no coverage.
	<u>Hospice services</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for out-of- <u>Network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.

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)	
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for 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
- Infertility Treatment
- Routine Foot Care
- Bariatric Surgery
- Long-Term Care
- Weight Loss Programs
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Dental Care (Adult/Child)
- Private Duty Nursing
- Glasses
- Routine eye care (Adult/Child)

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

- Chiropractic Care
- Hearing Aids

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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-866-673-6293. 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 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: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or www.oci.wi.gov.

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 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 1-866-673-6293.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-673-6293.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijigo holne' 1-866-673-6293.

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** \$ 3,000
- **Specialist coinsurance** 0%
- **Hospital (facility) coinsurance** 0%
- **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:	
<i>Cost Sharing</i>	
Deductible	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$ 3,000
- **Specialist coinsurance** 0%
- **Hospital (facility) coinsurance** 0%
- **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:	
<i>Cost Sharing</i>	
Deductible	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$ 3,000
- **Specialist coinsurance** 0%
- **Hospital (facility) coinsurance** 0%
- **Other coinsurance** 0%

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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductible	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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

Notice of Non-Discrimination

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)**, udostępniłmy 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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 ក៏មានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខគុកចេញថ្លៃ ដែលមានកក់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរាប់បញ្ចូល (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 yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqodí Naaltsoos Bee 'Aa'áhayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodílnih.

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).