

 **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 uhc.com/shopdc or by calling 1-877-856-2430. 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? | Designated <u>Network</u> and <u>Network</u> : \$2,500 Individual / \$5,000 Family out-of- <u>Network</u> : \$5,000 Individual / \$10,000 Family Per policy year. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes, Dental Deductible: Designated <u>Network</u> and <u>Network</u> : \$50 Individual/ \$100 Family There are no other specific deductibles. | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Designated <u>Network</u> and <u>Network</u> : \$7,000 Individual / \$14,000 Family out-of- <u>Network</u> : \$10,000 Individual / \$20,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balanced billing</u> is prohibited), health care this <u>plan</u> 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 uhc.com/shopDCdocfindchoiceplus or call 1-877-856-2430 for a list of <u>network providers</u> . | You pay the least if you use a <u>provider</u> in the Designated <u>network</u> . You pay more if you use a <u>provider</u> in the <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a 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 |
|--|--|--|---|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | 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 | \$30 <u>copay</u> per visit | \$60 <u>copay</u> per visit | 20% <u>coinsurance</u> | If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. Virtual visits (Telehealth) - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. No virtual coverage for out-of-Network. |
| | Specialist visit | \$50 <u>copay</u> per visit | \$100 <u>copay</u> per visit | 20% <u>coinsurance</u> | If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. |
| | Preventive care/screening/immunization | No Charge | No Charge | Not Covered | No coverage out-of-Network. Includes preventive health services specified in the health care reform law. 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) | Lab: 0% <u>coinsurance</u> X-ray: 0% <u>coinsurance</u> | Lab: 50% <u>coinsurance</u> X-ray: 0% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-Network Lab is not covered. <u>Preauthorization</u> required for out-of-Network for certain services or benefit reduces to 50% of allowed. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider and is covered at 50% <u>coinsurance</u> . |
| | Imaging (CT/PET scans, MRIs) | 0% <u>coinsurance</u> | 50% <u>coinsurance</u> | 20% <u>coinsurance</u> | \$500 per occurrence deductible for Network Benefits from a Network provider that is not a Designated Diagnostic Provider, applies prior to the overall deductible. <u>Preauthorization</u> required for out-of-Network or benefit reduces to 50% of allowed. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | 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 uhc.com/rxfind | Tier 1 - Your Lowest-Cost Option | Retail: \$10 <u>copay</u> Mail-Order: \$20 <u>copay</u> <u>Specialty Drugs**</u> : \$10 <u>copay</u> | Retail: \$10 <u>copay</u> Mail-Order: \$20 <u>copay</u> <u>Specialty Drugs**</u> : \$10 <u>copay</u> | Retail: \$10 <u>copay</u> <u>Specialty Drugs</u> : \$10 <u>copay</u> | <p>Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network Pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.</p> <p>**Your cost shown is for a Preferred Specialty Network Pharmacy. Non-Preferred Specialty Network Pharmacy: <u>Copay</u> is 2 times the Preferred Specialty Network Pharmacy <u>Copay</u> or the <u>coinsurance</u> (up to 50% of the <u>Prescription Drug Charge</u>) based on the applicable Tier.</p> <p><u>Copay</u> is per prescription order up to the day supply limit listed above.</p> <p>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. See the website listed for information on drugs covered by your <u>plan</u>. Not all drugs are covered. Prescription Drug List (PDL): Essential . Network: National You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.</p> <p>If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied.</p> |
| | Tier 2 - Your Midrange-Cost Option | Retail: \$40 <u>copay</u> Mail-Order: \$80 <u>copay</u> <u>Specialty Drugs**</u> : \$40 <u>copay</u> | Retail: \$40 <u>copay</u> Mail-Order: \$80 <u>copay</u> <u>Specialty Drugs**</u> : \$40 <u>copay</u> | Retail: \$40 <u>copay</u> <u>Specialty Drugs</u> : \$40 <u>copay</u> | |
| | Tier 3 - Your Midrange-Cost Option | Retail: \$75 <u>copay</u> Mail-Order: \$150 <u>copay</u> <u>Specialty Drugs**</u> : \$100 <u>copay</u> | Retail: \$75 <u>copay</u> Mail-Order: \$150 <u>copay</u> <u>Specialty Drugs**</u> : \$100 <u>copay</u> | Retail: \$75 <u>copay</u> <u>Specialty Drugs</u> : \$100 <u>copay</u> | |
| | Tier 4 - Additional High-Cost Options | Retail: \$125 <u>copay</u> Mail-Order: \$250 <u>copay</u> <u>Specialty Drugs**</u> : \$150 <u>copay</u> | Retail: \$125 <u>copay</u> Mail-Order: \$250 <u>copay</u> <u>Specialty Drugs**</u> : \$150 <u>copay</u> | Retail: \$125 <u>copay</u> <u>Specialty Drugs</u> : \$150 <u>copay</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surg Center: 0% <u>coinsurance</u> Hospital: 0% <u>coinsurance</u> | Ambulatory Surg Center: 0% <u>coinsurance</u> Hospital: 0% <u>coinsurance</u> | 20% <u>coinsurance</u> | <p><u>Preauthorization</u> required for certain services for out-of-Network or benefit reduces to 50% of allowed. \$350 Hospital-based per occurrence <u>deductible</u> applies prior to the overall <u>deductible</u>.</p> |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|--|----------------------------------|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$350 <u>copay</u> per visit | \$350 <u>copay</u> per visit | \$350 <u>copay</u> per visit | None |
| | <u>Emergency medical transportation</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | \$60 <u>copay</u> per visit | \$60 <u>copay</u> per visit | 20% <u>coinsurance</u> | If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 <u>copay</u> per admission | \$500 <u>copay</u> per admission | 20% <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> | 0% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$60 <u>copay</u> per visit | \$60 <u>copay</u> per visit | 20% <u>coinsurance</u> | <u>Network</u> 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. |
| | Inpatient services | \$500 <u>copay</u> per admission | \$500 <u>copay</u> per admission | 20% <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 | No Charge | 20% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply. |
| | Childbirth/delivery professional services | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | 20% <u>coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---------------------------------------|--|---|---|---|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | \$500 copay per admission | \$500 copay per admission | 20% coinsurance | Additional copays, deductibles, coinsurance may apply. Inpatient preauthorization apply for out-of-Network 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 | Home health care | 0% coinsurance | 0% coinsurance | 20% coinsurance | Limited to 90 visits up to 4 hours per visit per "episode of care". Preauthorization required for out-of-Network or benefit reduces to 50% of allowed. |
| | Rehabilitation services | \$60 copay per outpatient visit | \$60 copay per outpatient visit | 20% coinsurance | Limits per policy year: Physical, Speech, Occupational: Pulmonary: Unlimited. Cardiac: 90 visits. |
| | Habilitation services | \$60 copay per outpatient visit | \$60 copay per outpatient visit | 20% coinsurance | Limits per policy year: Physical, Speech, Occupational: Unlimited. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit to 50% of allowed. |
| | Skilled nursing care | \$500 copay per admission | \$500 copay per admission | 20% coinsurance | Skilled nursing is limited to 60 days per policy year. (Inpatient Rehabilitation and Habilitation limited to 90 days each). Preauthorization required for out-of-Network or benefit reduces to 50% of allowed. |
| | Durable medical equipment | 0% coinsurance | 0% coinsurance | Not covered | Covers 1 per type of Durable medical equipment (including replace) every 2 years. Repairs are unlimited. |
| | Hospice services | 0% coinsurance | 0% coinsurance | 20% coinsurance | Preauthorization required for out-of-Network 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 | \$30 copay per visit, deductible does not apply | \$30 copay per visit, deductible does not apply | 50% coinsurance | One exam every 12 months. |
| | Children's glasses | 50% coinsurance | 50% coinsurance | 50% coinsurance | One pair every 12 months. |
| | Children's dental check-up | 0% coinsurance | 0% coinsurance | 0% coinsurance | Cleanings covered 2 times per 12 months. |

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.)

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

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

- Acupuncture - Anesthesia only
- Chiropractic care
- Hearing Aids - \$2,500/policy year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 1-877-856-2430. 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: 1-877-856-2430 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the District of Columbia Department of Insurance, Securities, and Banking at 202-727-8000 or disr.washingtondc.gov/disr/site. Additionally, a consumer assistance program can help you file your appeal. Contact DC Office of the Health Care Ombudsman and Bill of Rights at 1-877-685-6391 or visit healthcareombudsman@dc.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 1-877-856-2430.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-856-2430.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-856-2430.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiiijigo holne' 1-877-856-2430.

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** \$ 2,500
- **Specialist copayment** \$100
- **Hospital (facility) copayment** \$500
- **Other coinsurance** 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

| | |
|---------------------------|----------|
| Total Example Cost | \$12,700 |
|---------------------------|----------|

In this example, Peg would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductible</u> | \$2,500 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| 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** \$ 2,500
- **Specialist copayment** \$100
- **Hospital (facility) copayment** \$500
- **Other coinsurance** 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

| | |
|---------------------------|---------|
| Total Example Cost | \$5,600 |
|---------------------------|---------|

In this example, Joe would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductible</u> | \$2,500 |
| <u>Copayments</u> | \$600 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|---------|
| The total Joe would pay is | \$3,100 |
|-----------------------------------|---------|

Mia's Simple Fracture

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

- **The plan's overall deductible** \$ 2,500
- **Specialist copayment** \$100
- **Hospital (facility) copayment** \$500
- **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:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductible</u> | \$2,500 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|---------|
| The total Mia would pay is | \$2,700 |
|-----------------------------------|---------|

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។ សូមទូរស័ព្ទទៅលេខឥតថ្លៃ 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 jíílk'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 jíílk'ehgo béésh 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).