



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.uhcsr.com/csm](http://www.uhcsr.com/csm) or call 1-800-767-0700. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Preferred Providers</u> \$0 / (Person) <u>Out-of-Network Provider</u> \$1,000 / (Person)	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.
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	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.
<u>What is the out-of-pocket limit for this plan?</u>	<u>Preferred Providers</u> \$2,000 / (Person) <u>Out-of-Network Provider</u> \$4,000 / (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.uhcsr.com/csm">www.uhcsr.com/csm</a> or call 1-800-767-0700 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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</u> charge 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.
<u>Do you need a referral to see a specialist?</u>	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
		Preferred 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	\$25 <u>Copay</u> /per visit	\$25 <u>Copay</u> /per visit 40% <u>Coins</u>	<b>Student Health Center Benefits:</b> The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Routine/Preventative Labs referred by the SHC to LabCorp will be paid at 100%. All Other labs referred by the SHC to Lab Corp will be paid at 80%. Policy Exclusions and Limitations do not apply. May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$25 <u>Copay</u> /per visit 20% <u>Coins</u>	\$25 <u>Copay</u> /per visit 40% <u>Coins</u>	
	<u>Preventive</u> care/screening/immunization	No Charge	40% <u>Coins</u>	
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coins</u>	40% <u>Coins</u>	none
	Imaging (CT/PET scans, MRIs)	20% <u>Coins</u>	40% <u>Coins</u>	none
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	Not Covered	Preferred Providers: up to a 30 day supply per prescription  You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us.  You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> .  You may pay more if <u>prior authorization</u> is not obtained.
	Tier 2 - Your Midrange-Cost Option	\$30 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply		
	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 4 - Additional High-Cost Option	Not Covered		For a twin-pack of epinephrine injectors, regardless of the type of epinephrine injector, the total amount of Copayments or Coinsurance shall not exceed \$60.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	40% <u>Coins</u>	—————none—————
	Physician/surgeon fees	20% <u>Coins</u>	40% <u>Coins</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>Copay</u> /per visit 20% <u>Coins</u>	\$100 <u>Copay</u> /per visit 20% <u>Coins</u> <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	<u>Emergency medical transportation</u>	No Charge	No Charge <u>ded</u> does not apply	—————none—————
	<u>Urgent care</u>	\$35 <u>Copay</u> /per visit	\$35 <u>Copay</u> /per visit <u>ded</u> does not apply	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Miscellaneous Expenses: 20% <u>Coins</u> Room and Board Expense: 20% <u>Coins</u> \$250 <u>Copay</u> per Hospital Confinement	Hospital Miscellaneous Expenses: 40% <u>Coins</u> Room and Board Expense: 40% <u>Coins</u> <u>ded</u> does not apply	—————none—————
	Physician/surgeon fees	20% <u>Coins</u>	Anesthetist Services: 40% <u>Coins</u> Assistant Surgeon Fees: 40% <u>Coins</u> Physician's Visits: 40% <u>Coins</u> <u>ded</u> does not apply Surgery: 40% <u>Coins</u>	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: \$25 <u>Copay</u> /per visit Other: 20% <u>Coins</u>	Office Visits: 40% <u>Coins</u> \$25 <u>Copay</u> /per visit Other: 40% <u>Coins</u>	none
	Inpatient services	\$250 <u>Copay</u> per Hospital Confinement 20% <u>Coins</u>	40% <u>Coins</u> <u>ded</u> does not apply	none
<b>If you are pregnant</b>	Office visits	\$25 <u>Copay</u> /per visit	\$25 <u>Copay</u> /per visit 40% <u>Coins</u>	<u>Cost-sharing</u> does not apply for preventive services when provided by a <u>preferred provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>Coins</u>	40% <u>Coins</u>	
	Childbirth/delivery facility services	Hospital Miscellaneous Expenses: 20% <u>Coins</u> Room and Board Expense: 20% <u>Coins</u> \$250 <u>Copay</u> per Hospital Confinement	Hospital Miscellaneous Expenses: 40% <u>Coins</u> Room and Board Expense: 40% <u>Coins</u> <u>ded</u> does not apply	none
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>Coins</u>	40% <u>Coins</u>	none
	<u>Rehabilitation services</u>	Inpatient Rehabilitation Facility: 20% <u>Coins</u> \$250 <u>Copay</u> per Hospital Confinement Physiotherapy: 20% <u>Coins</u>	Inpatient Rehabilitation Facility: 40% <u>Coins</u> <u>ded</u> does not apply Physiotherapy: 40% <u>Coins</u>	Inpatient 60 days maximum (Per Policy Year) Outpatient 20 visits of physical therapy Outpatient 20 visits of occupational therapy Outpatient 20 visits of speech therapy Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	20% <u>Coins</u>	40% <u>Coins</u>	Outpatient 20 visits of physical therapy Outpatient 20 visits of occupational therapy Outpatient 20 visits of speech therapy Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	<u>Skilled nursing care</u>	20% <u>Coins</u>	40% <u>Coins</u>	100 days maximum (Per Policy Year)
	<u>Durable medical equipment</u>	20% <u>Coins</u>	40% <u>Coins</u>	none
	<u>Hospice services</u>	20% <u>Coins</u>	40% <u>Coins</u>	none
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered <u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/csm](http://www.uhcsr.com/csm)

## 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
- Cosmetic surgery
- Dental care (Adult) except as specifically provided in the Policy
- Hearing aids
- Infertility treatment
- Long-term care except as specifically provided in the Policy
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) except as specifically provided in the Policy
- 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.)

- Chiropractic care
- Private-duty nursing

**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: UnitedHealthcare Student Resources at 1-800-767-0700 and Colorado Division of Insurance at 1-303-894-7490 or visit <http://www.dora.state.co.us/insurance/>. 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](http://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: Colorado Division of Insurance at 1-303-894-7490 or visit <http://www.dora.state.co.us/insurance/>.

**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? Not Applicable.**

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 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-260-2723.

*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 <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

**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
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**In this example, Peg would pay:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,090</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$5,600
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**In this example, Joe would pay:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	\$2,800
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**In this example, Mia would pay:**

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

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

# Notice of Non-Discrimination

We<sup>1</sup> comply with the applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans (TTY 711).

Civil Right Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

If you need help with your complaint, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans. (TTY 711).

You can also file a complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights:

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
**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

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

This notice is available at: <https://www.uhc.com/content/dam/uhcdotcom/en/npp/NDN-LA-UHC-StudentResources-EN.pdf>

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<sup>1</sup>For purposes of the Language Assistance Services and this Non-Discrimination Notice (“Notice”), “We” refers to the following entities: Dental Benefit Providers, Inc.; Health Allies, Inc.; Spectera, Inc.; UMR, Inc.; United Behavioral Health,; United Behavioral Health of New York, I.P.A.; UnitedHealthcare Insurance Company; and UnitedHealthcare Insurance Company of New York. Please note that not all entities listed are covered by this Notice.

**NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS**

**ATTENTION:** You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free phone number listed on your ID card. (TTY: 711).

يرجى الاتصال: يمكنك الحصول على مترجم فوري لمساعدتك في التحدث مع طبيبك خلال الموعد أو معاً. إذا كنت تحدث اللغة العربية (Arabic)، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية برسائل أخرى، مثل الطباعة بأحرف كبيرة. اتصل على 23-260-1-866-2723 لخطط الطبية، أو 3120-800-638-1 لخططرعاية البصر، أو 3596-816-877-1 لخطط الأسنان، أو احصل برقم الهاتف المجاني المدرج على بطاقة هوية الجندي الخاصة بك (7111: TTY) (111: TTY).

**মনোযোগ দিয়ে শুনুন:** আপনার অ্যাপয়েন্টমেন্টের সময় আপনার ডাক্তারের সাথে কথা বলার জন্য বা আমাদের সাথে কথা বলার জন্য আপনি একজন দোভাসী পেতে পারেন। আপনি যদি বাংলা (Bengali) এ কথা বলেন, তাহলে বিনামূল্যের ভাষা সহজে পরিষেবা এবং অন্যান্য বিনামূল্যের বিভিন্ন যোগাযোগ পদ্ধতি, যেমন বড় মুদ্রণ, আপনার জন্য উপলব্ধ থাকবে। মেডিকেল প্ল্যানের জন্য কল করুন 1-866-260-2723 নম্বরে, ভিশন প্ল্যানের জন্য কল করুন 1-800-638-3120 নম্বরে, ডেন্টাল প্ল্যানের জন্য কল করুন 1-877-816-3596 নম্বরে, অথবা আপনার সদস্য আইডি কার্ডে টোল-ফ্রি ফোন নম্বরে কল করুন। (TTY: 711)

**ATENSHUN:** Kuŋka me liye ayu yo interprete para ughul maghal na dokto ya eppunghi me guahu. Gare kapetal Faluwasch (Carolinian), ye toore paliuwal kapetal Faluwasch lane bwe me sew format, ta tipel lane, bwe bwale tepangiyom. Kali 1-866-260-2723 para ughul Lalap ni ughul tipiye, 1-800-638-3120 para ughul Lalap ni tipiye nu mata, 1-877-816-3596 para ughul Lalap ni tipiye nu apapa, o kali ewe kali rerekkepal ni Nuumur ni telepon yeeg listed me ni Kaaret ni meybur ID-mu. (TTY: 711).

**ATENSYON:** Siña hao humosga un intérprete para kumuentos yan i doktermu gi ora di i konsulta-mu pat yan hame. Yanggen fifino' hao **Chamorro (Chamorro)**, guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'esiha gi otro na manera siha, taiguui i para mana'dångkolo i inemprenta. Kålle 1-866-260-2723 para Planåñ Mediku, 1-800-638-3120 para Planåñ Visión, 1-877-816-3596 para Planåñ Dental, pat kålle i númeru gratut na teleponu na esta på'go gi kåtta ID para miembro -mu. (TTY: 711)

**請注意：**您可以獲得一位口譯員，在您看診時與您的醫生溝通或平常與我們溝通。如果您說**中文 (Chinese)**，我們可為您提供免費的語言協助服務與其他溝通格式，例如大字版文件。醫療計劃請致電**1-866-260-2723**，視力計劃請致電**1-800-638-3120**，牙科計劃請致電**1-877-816-3596**，或撥打您會員卡上所列的免付費電話號碼。(TTY : 711)。

**توجه:** شما می‌توانید یک مترجم برای صحبت با یزشک خود در زمان ویزیت با برای گفتگو با ما، درخواست کنید. اگر فارسی (Farsi) صحبت می‌کنید، خدمات رایگان کمک زبانی و خدمات رایگان ارتباطی در سایر قالب‌ها، مانند چاپ با حروف درشت، در سیرس شما هستند. برای برنامه‌های یزشکی با شماره **1-866-260-2723** و برای طرح چشم یزشکی با شماره **1-800-638-3120** و برای طرح دندانیزشکی با شماره **1-877-816-3596**، یا با (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط طن رایگان سازمان

**ATTENTION :** Vous pouvez demander à un(e) interprète de parler à votre médecin au moment de votre rendez-vous ou avec nous. Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le **1-866-260-2723** pour les régimes médicaux, le **1-800-638-3120** pour les régimes de soins de la vue, le **1-877-816-3596** pour les régimes de soins dentaires, ou appelez le numéro de téléphone gratuit indiqué sur votre carte de membre. (TTY : 711).

**ACHTUNG:** Sie können für Gespräche mit Ihrem Arzt bei Ihrem Termin oder mit uns einen Dolmetscher anfordern. Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistentendienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie **1-866-260-2723** für Krankenversicherungen, **1-800-638-3120** für Augenversicherungen, **1-877-816-3596** für Zahnversicherungen oder die gebührenfreie Telefonnummer auf Ihrer Mitgliedskarte an. (TTY: 711).

**ΠΡΟΣΟΧΗ:** Μπορείτε να πάρετε έναν διερμηνέα για να μιλήσετε με το γιατρό σας στο ραντεβού σας ή για να μιλήσετε μαζί μας. Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε στο **1-866-260-2723** για ιατρικά προγράμματα, στο **1-800-638-3120** για οφθαλμολογικά προγράμματα, στο **1-877-816-3596** για οδοντιατρικά προγράμματα ή καλέστε τον αριθμό τηλεφώνου χωρίς χρέωση που αναγράφεται στην κάρτα μέλους σας. (TTY: 711).

**ધ્યાન આપો:** તમે તમારી મુલાકાત સમયે અથવા અમારી સાથે તમારા ડોક્ટર સાથે વાત કરવા માટે કુભાણી મેળવી શકો છો. જો તમે ગુજરાતી (Gujarati), બોલો છો, તો મફત ભાષા સહાયતા સેવાઓ અને અન્ય ફોર્મેટમાં મફત સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. મેડિકલ પ્લાન માટે **1-866-260-2723**, વિજન પ્લાન માટે **1-800-638-3120**, ડેન્ટલ પ્લાન માટે **1-877-816-3596** પર કોલ કરો અથવા તમારા સભ્ય આઈડી કાર્ડ પર સ્થિરબદ્ધ ટોલ-ફોન નંબર પર કોલ કરો. (TTY: 711).

**ATANSYON:** Ou ka jwenn yon entèprèt pou pale ak doktè ou a nan moman randevou w la oswa avèk nou. Si w pale **Kreyòl Ayisyen (Haitian Creole)**, sèvis asistans lang gratis ak komunikasyon gratis nan lòt fòma, tankou gwo lèt, disponib pou ou. Rele **1-866-260-2723** pou Plan Medikal, **1-800-638-3120** pou Plan Vizyon, **1-877-816-3596** pou Plan Dantè, oswa rele nimewo telefòn gratis ki endike sou kat ID manm ou a. (TTY: 711).

**ध्यान दें:** आप अपनी अपॉइंटमेंट के समय या हमारे साथ अपने डॉक्टर से बात करने के लिए एक दुभाषिया प्राप्त कर सकते हैं। यदि आप हिन्दी (Hindi) बोलते हैं, तो मुफ्त भाषा सहायता सेवाएँ और बड़े प्रिंट जैसे अन्य प्रारूपों में मुफ्त संचार सेवा आपके लिए उपलब्ध हैं। मेडिकल प्लान के लिए 1-866-260-2723 पर कॉल करें, विजन प्लान के लिए 1-800-638-3120 पर, डैंटल प्लान के लिए 1-877-816-3596 पर कॉल करें, या अपने सदस्य आईडी कार्ड पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें। (TTY: 711)

**CEEB TOOM:** Koj tuaj yeem tau txais ib tug neeg txhais lus tham nrog koj tus kws kho mob thaum lub sijhawm kev teem caij los sis thaum tham nrog peb. Yog tias koj hais **Lus Hmoob (Hmong)**, yuav muaj cov kev pab cuam txhais lus pub dawb thiab kev sib txaus lus ua lwm hom qauv, xws li luam ua tus ntawv loj rau koj. Hu rau **1-866-260-2723** rau Cov Phiaj Xwm Kho Mob, **1-800-638-3120** rau Cov Phiaj Xwm Kho Qhov Muag, **1-877-816-3596** rau Cov Phiaj Xwm Kho Hniav, los yog hu rau tus xov tooj hu dawb uas teev rau hauv koj daim npav ID. (TTY: 711).

**ATENSIÓN:** Makaalaka iti interpreter a makisarita kadakami weno iti doktormo iti oras ti appointment-mo. No makasaoka iti Ilocano (Ilocano), makaalaka iti libre a tulong iti lengguahé ken libre a pannakikomunikar iti sabali a format, kas iti dadakkel a letra. Tawagam ti **1-866-260-2723** para kadagiti Plan a Medikal, **1-800-638-3120** para kadagiti Plan para iti Panagkita, **1-877-816-3596** para kadagiti Plan para iti Ngipen, weno tawagam ti libre a numero ti telefono a nailista iti ID card-mo kas miembro. (TTY: 711).

**ATTENZIONE:** il giorno del Suo appuntamento, può richiedere i servizi di un interprete per parlare con il Suo medico o con noi. Se parla italiano (Italian), sono disponibili gratuitamente servizi di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero **1-866-260-2723** per i piani sanitari, il numero **1-800-638-3120** per i piani oculistici e il numero **1-877-816-3596** per i piani dentistici, oppure chiami il numero verde riportato sul Suo tesserino identificativo. (TTY: 711).

**ご注意:** ご予約にお越しの際またはご来院の際、医師とお話になるための通訳者を手配することができます。あなたが<sup>9</sup>日本語 (Japanese) をお話になる場合、無料の言語支援サービスおよび大きい活字など他の形式による無料のコミュニケーションをご利用になれます。医療プランについては **1-866-260-2723**、眼科プランについては **1-800-638-3120**、歯科プランについては **1-877-816-3596** までお電話いただき、メンバー ID カードに記載の通話料無料の番号までお電話ください。 (TTY: 711)。

**주의:** 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다.

한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 큰 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 의료 플랜의 경우 **1-866-260-2723**, 안과 플랜의 경우 **1-800-638-3120**, 치과 플랜의 경우 **1-877-816-3596** 번으로 전화하거나 귀하의 회원 ID 카드에 기재된 무료 전화번호로 전화하십시오. (TTY: 711).

**ສາທາລະນະລັດ ປະຊາທິປະໄຕ ປະຊາຊົນລາວ** ເຊິ່ງກັບທ່ານໝູນໃນວ່າທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ ເມືອງວຽງຈັນ (Vientiane), ການປ່ວມການປຸ່ວຍເຫຼືອດ້ານ ເມືອງ ເພື່ອ ການອື່ນເປົ້າພົມໃນຊູບແບບອື່ນງ, ດັ່ງນີ້: ການຜົມຂະໜາດ ໄຫຍໍ, ແມ່ນມີໃຫ້ທ່ານ. ໃຫ້ **1-866-260-2723** ອ່າວັບແຜນການທາງການແພດ, **1-800-638-3120** ອ່າວັບແຜນການທາງອາຍຕາ, **1-877-816-3596** ອ່າວັບແຜນການທາງແຂວງ, ຫຼື ໄຫຍໍເປົ້າພົມໃຫ້ພົມທີ່ວະບຸໄວ້ໃນບັດປະຈຳຕົວອະນາຄຸມກອງທ່ານ. (TTY: 711).

**SHOOH:** Nánihoot'áaní góne' ne'azee' iil'íní bich'í' yánílti' doodago nihí nihich'í' yánílti'go ata' halne'í la' naayilt'eehgo biiighah. **Diné (Navajo)** bizaad bee yánílti'to, t'áá jiik'eh saad bee áka'e'eyeed bee áka'anída'ow'í dóó t'áá jiik'eh nááná ɬahgo át'éego bee hada'dilyaaígíí bee ahíł hane', dií nitsaago bik'e'ashchíní, ná dahólo. Ats'iis Nánél'íjh Bee Hada'dít'éhí biniiyé kohji' 1-866-260-2723 hodílnih, Anáá' Bee Hoot'íní Bee Hada'dít'éhí biniiyé kohji' 1-877-816-3596 hodílnih, doodago bee nił ha'dít'éhí ninaaltsoos nitl'izí bee nééhózini ID baqh t'áá jiik'eh námboo bee dahane'i biká'ígíí bee hodílnih. (TTY: 711).

**द्यान दिनुहोस्:** तपाईंले आफ्नो अपोइन्टमेन्टको समयमा वा हामीसँग आफ्नो डाक्टरसँग कुरा गर्न दोभाषे लिन सक्नुहुन्छ। तपाईं नेपाली (Nepali) बोल्नुहुन्छ भने, जिःशुल्क भाषा सहायता सेवाहरु र ठूलो अक्षर जस्ता अन्य ढाँचाहरूमा जिःशुल्क सञ्चार सेवाहरु तपाईंको लागि उपलब्ध छन्। चिकित्सा योजनाहरूको लागि 1-866-260-2723 अंजन योजनाहरूको लागि 1-800-638-3120 दन्त योजनाहरूको लागि 1-877-816-3596 मा कल गर्नुहोस्, वा तपाईंको सदस्य परिचयपत्रमा सूचीबद्ध टोल-फ्री फोन नम्बरमा कल गर्नुहोस्। (TTY: 711)

**WICHDICHT:** Du darfscht en Interpreter griege fer schwetze mit dei Dokter an dei Appointment odder mit uns. Wann du **Deitsch (Pennsylvania Dutch)** schwetscht un brauchscht Hilf fer communicat-e, kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Call 1-866-260-2723 fer Plans as zu duh hen mit Dokteres, 1-800-638-3120 fer Plans as zu duh hen mit Sehne, 1-877-816-3596 fer Plans as zu duh hen mit Zaeh, odder call die Toll-Free Phone Number as uff dei ID Card is. (TTY: 711).

**UWAGA:** Możesz poprosić tłumacza o pomoc w rozmowie z lekarzem w czasie wizyty lub z nami. Osoby mówiące w języku **polskim (Polish)**, mają dostęp do bezpłatnej usługi pomocy językowej i bezpłatnej komunikacji w innych formatach, takich jak duży druk. Zadzwoń pod numer 1-866-260-2723 w celu uzyskania informacji o planach medycznych, 1-800-638-3120 o planach okulistycznych, 1-877-816-3596 o planach stomatologicznych lub zadzwoń pod bezpłatny numer telefonu podany na karcie członkowskiej. (TTY: 711).

**ATENÇÃO:** Você pode ter um intérprete para falar com o médico no momento da consulta ou conosco. Se você fala português (Portuguese), há serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, disponíveis para você. Ligue para 1-866-260-2723 para planos médicos, 1-800-638-3120 para planos oftalmológicos, 1-877-816-3596 para planos odontológicos ou ligue para o número de telefone gratuito listado no seu cartão de ID de membro. (TTY: 711).

**ਪਿਆਨ ਦਿਓ:** ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਈਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਭਾਸੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਹਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਡਾਰਮੈਂਟਾਂ ਵਿੱਚ ਮੁਹਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਅੰਖਾਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਸੈਡੀਕਲ ਯੋਜਨਾਵਾਂ ਲਈ 1-866-260-2723, ਵਿਜਨ ਯੋਜਨਾਵਾਂ ਲਈ 1-800-638-3120, ਡੈਂਟਲ ਯੋਜਨਾਵਾਂ ਲਈ 1-877-816-3596 'ਤੇ ਕਾਲ ਕਰੋ, ਜਾਂ ਆਪਣੇ ਮੈਂਬਰ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਟੋਲ-ਫ੍ਰੀ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

**ВНИМАНИЕ!** Вы можете воспользоваться услугами устного переводчика для общения с вашим врачом во время приема или через наши услуги. Если вы говорите на **русском языке (Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Позвоните по телефону **1-866-260-2723** для медицинских планов, **1-800-638-3120** для планов по охране зрения, **1-877-816-3596** для планов по стоматологическим услугам или на линию для бесплатного звонка, указанную на вашей идентификационной карточке участника. (Линия ТTY: 711).

**FA'AALIGA:** Afai e te tautala i le **Faa-Samoa** (Samoan), o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au 1-866-260-2723 mo Fuafuaga Fa'afoma'i, 1-800-638-3120 mo Fuafuaga Va'ai, 1-877-816-3596 mo Fuafuaga Nifo, pe vala'au le numera telefoni e leai se totogi o lo'o lisiina i luga o lau pepa ID taqata. (TTY: 711).

**FIIRO GAAR AH:** Waxaad heli kartaa turjumaan si aad ula hadasho dhakhtarkaaga wakhtiga ballanta ama annaga. Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, aaya diyaar kuu ah. Wac **1-866-260-2723** wixii ah Qorshayaasha Caafimaadka, **1-800-638-3120** Qorshooyinka Aragtida, **1-877-816-3596** wixii ah Qorshooyinka Ilkaha, ama wac lambarka telefoonka bilaashka ah ee ku qoran kaarka aqoonsiga xubinta. (TTY: 711).

**ATENCIÓN:** Puede conseguir un intérprete para hablar con nosotros o con su médico durante su cita. Si usted habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia en otros idiomas y comunicaciones gratuitas en otros formatos, como letra grande. Llame al **1-866-260-2723** para los planes médicos, al **1-800-638-3120** para los planes de la vista y al **1-877-816-3596** para los planes dentales, o llame al número de teléfono gratuito que aparece en su tarjeta de identificación de membresía. (TTY: 711).

**PAUNAWA:** Maaari kang makakuha ng interpreter upang makausap ang iyong doktor sa panahon ng iyong appointment o sa pakikipag-usap sa amin. Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa 1-866-260-2723 para sa Mga Planong Medikal, 1-800-638-3120 para sa Mga Plano para sa Paninig, 1-877-816-3596 para sa Mga Plano para sa Ngipin, o tumawag nang libre sa numero ng telefono na nakalista sa iyong ID card ng miyembro. (TTY: 711)

หมายเหตุ: คุณสามารถขอตัวมาพูดคุยกับพยาบาลของคุณได้ในเวลาที่คุณต้องการหรืออ่านเรื่องราวดูพูดภาษาไทย (Thai) เว็บไซต์ที่ให้บริการว่าด้วยเพื่อศึกษาภาษาและการเรียนรู้ในรูปแบบอื่นๆ เช่น การพิมพ์ที่ถูกต้องอักษรไทยไม่เกิดค่าใช้จ่าย โทร 1-866-260-2723 สำหรับการวางแผนทางการแพทย์ 1-800-638-3120 สำหรับการวางแผนด้านลักษณะ 1-877-816-3596 สำหรับการวางแผนด้านทักษะการรักษา หรือไปที่รับบัตร์หมายเหตุที่ระบุไว้ในบัตร์นี้และติดต่อ บริการฉุกเฉิน (TTY: 711)

**ЗВЕРНІТЬ УВАГУ!** Під час прийому у лікаря або розмови з нами ви маєте змогу скористатися послугами усного перекладача. Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як-от набрані великим шрифтом. Телефонуйте на номер **1-866-260-2723** щодо планів медичного страхування, на номер **1-800-638-3120**, щоб дізнатися докладніше про плани страхового покриття офтальмологічних послуг, на номер **1-877-816-3596**, щоб дізнатися докладніше про плани страхового покриття стоматологічних послуг, або телефонуйте на номер безкоштовної телефонної лінії, зазначений на вашій ідентифікаційній картці учасника. (лінія TTY: 711).

توجه فرمائیں: اب اپنی ملکات کے وہ باماری سائے اپنے ڈاکٹر سے بات کریے کہ لیے مترجم حاصل کر سکتے ہیں۔ اگر اپنے (Urdu) بولائے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیش میڈیا بڑے برقہ میں مفت مواصلات اپ کے لیے دستیاب ہیں۔ میڈیکل یانٹر کے لیے 866-260-2723، ویزن یانٹر کے لیے 1-800-638-3120، ٹیکش یانٹر کے لیے 1-877-816-3596 یا کال کریں، یا (TTY: 711) ।

**LƯU Ý:** Quý vị có thể có một thông dịch viên miễn phí để nói chuyện với bác sĩ trong buổi hẹn khám của mình hoặc nói chuyện với chúng tôi. Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Hãy gọi **1-866-260-2723** cho các Chương trình Y tế, **1-800-638-3120** cho các Chương trình Nhãn khoa, **1-877-816-3596** cho các Chương trình Nha khoa, hoặc gọi số điện thoại miễn phí được ghi trên thẻ ID hội viên của quý vị. (TTY: 711).