



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/sfcm](http://www.uhcsr.com/sfcm) or call 1-800-505-4160. 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 1-800-505-4160 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Preferred Providers</u> \$200 / (Person) <u>Out-of-Network Provider</u> \$600 / (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.
<b>Are there services covered before you meet your deductible?</b>	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> .
<b>Are there other deductibles for specific services?</b>	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.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Preferred Providers</u> \$7,500 / (Person) <u>Preferred Providers</u> \$13,700 / (Family) <u>Out-of-Network Provider</u> \$15,000 / (Person)	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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.uhcsr.com/sfcm">www.uhcsr.com/sfcm</a> or call 1-800-505-4160 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.
<b>Do you need a referral to see a specialist?</b>	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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	20% <u>Coins</u>	50% <u>Coins</u>	May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	20% <u>Coins</u>	50% <u>Coins</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>Coins</u>	50% <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/stmarys-ca/pdl">www.uhcsr.com/stmarys-ca/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$25 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$60 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail Order <u>Network Pharmacy</u> or Preferred 90 Day Retail <u>Network Pharmacy</u> at 2 times the retail <u>Copay</u> up to a 90-day supply <u>Out-of-Network Provider</u> : up to a 31 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. Prescription Drugs covered under the Preventive Care Services benefit will be paid at the benefit levels shown under Preventive Care Services.
	Tier 2 - Your Midrange-Cost Option	\$60 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$60 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	
	Tier 3 - Your Highest-Cost Option	\$75 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	\$25 <u>Copay</u> per prescription generic drug \$60 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	

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

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)	
				For oral chemotherapeutic agents, the amount of any applicable Deductibles, Copayments or Coinsurance combined shall not exceed \$100 per Prescription Order or Refill up to a 31-day supply, regardless of tier placement.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>Coins</u> \$150 <u>Copay</u> /per visit <u>ded</u> does not apply	50% <u>Coins</u> \$150 <u>Copay</u> /per visit <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>	20% <u>Coins</u>	20% <u>Coins</u>	_____none_____
	<u>Urgent care</u>	20% <u>Coins</u> \$50 <u>Copay</u> /per visit	50% <u>Coins</u> \$50 <u>Copay</u> /per visit	May be limited to facility fees.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: 20% <u>Coins</u> Other: 20% <u>Coins</u>	Office Visits: 50% <u>Coins</u> Other: 50% <u>Coins</u>	_____none_____
	Inpatient services	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
<b>If you are pregnant</b>	Office visits	Based on setting where service is performed	Based on setting where service is performed	<u>Cost-sharing</u> does not apply for <u>preventive services</u> 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	Based on setting where service is performed	Based on setting where service is performed	
	Childbirth/delivery facility services	Based on setting where service is performed	Based on setting where service is performed	_____none_____

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

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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Rehabilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Skilled nursing care</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	20% <u>Coins</u>	20% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	20% <u>Coins</u>	50% <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/sfcm](http://www.uhcsr.com/sfcm)

## 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 except as specifically provided in the policy
- Dental care (Adult) except as specifically provided in the policy
- Hearing aids except as specifically provided in the policy
- Infertility treatment
- Long-term care except as specifically provided in the policy
- 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.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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 1-800-505-4160 and Ohio Department of Insurance at 1-800-686-1526 or visit <http://www.insurance.ohio.gov/Pages/default.aspx>. 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: Ohio Department of Insurance at 1-800-686-1526 or visit <http://www.insurance.ohio.gov/Pages/default.aspx>.

**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, kwijigo 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</u> overall <u>deductible</u>	\$200
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,770</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</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/uhc.com/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).

**ጥንቅቅ፡-** በቀጠሮታ ጊዜ ወይም ከእኛ ጋር ሲሆኑ ከተከፈለዎታል ጋር በመነጋገር አስተርጓሚ ግጥም ለማግኘት ይችላሉ። **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎቶች እና ነፃ ግንኙነቶች እንደ ጥራት ህትመት ባሉ ሌሎች ቅርጾች ለእርስዎ ይገኛሉ። ለህክምና ሰቅዶች ወደ **1-866-260-2723**፣ ለእይታ ሰቅዶች ወደ **1-800-638-3120**፣ ለጥርስ ሰቅዶች ወደ **1-877-816-3596** ይደውሉ ወይም በአባል መታወቂያ ካርድዎ ላይ ወደተዘረዘረው ነፃ የስልክ ቁጥር ይደውሉ። (TTY: 711)።

يرجى الانتباه: يمكنك الحصول على مترجم فوري لمساعدتك في التحدث مع طبيبك خلال الموعد أو معنا. إذا كنت تتحدث اللغة العربية (Arabic)، ستوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتسجيلات أخرى، مثل الطباعة بأحرف كبيرة. اتصل على **1-866-260-2723** للخطط الطبية، أو **1-800-638-3120** لخطط رعاية البصر، أو **1-877-816-3596** لخطط الأسنان، أو اتصل برقم الهاتف المجاني المدرج على بطاقة هوية العضو الخاصة بك. (TTY: 711)

**মনোযোগ দিয়ে শুনুন:** আপনার অ্যাপয়েন্টমেন্টের সময় আপনার ডাক্তারের সাথে কথা বলার জন্য বা আমাদের সাথে কথা বলার জন্য আপনি একজন দোভাষী পেতে পারেন। আপনি যদি বাংলা (Bengali) এ কথা বলেন, তাহলে বিনামূল্যের ভাষা সহায়তা 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)

**ចំណាំ:** អ្នកអាចស្នើសុំអ្នកបកប្រែ ដើម្បីទំនាក់ទំនងជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាដែល ប្រសិទ្ធភាពជាមួយយើងខ្ញុំ។ បើសិនអ្នកនិយាយ**កម្ពុជា-ខ្មែរ (Cambodian Mon-Khmer)** មានសេវាជំនួយភាសា ដោយឥតគិតថ្លៃ ការទំនាក់ទំនងដោយឥតគិតថ្លៃ ក្នុងទម្រង់ផ្សេងទៀត ដូចជាអត្រាជ្រាប មានសម្រាប់អ្នក សូមហៅទូរស័ព្ទទៅ **1-866-260-2723** សម្រាប់ការប្រោសផ្លូវសាស្ត្រ **1-800-638-3120** សម្រាប់ការប្រោសថែទាំខ្លួន **1-877-816-3596** សម្រាប់ការប្រោសថែទាំផ្លូវ ឬហៅទូរស័ព្ទទៅលេខទូរស័ព្ទដោយមិនគិតថ្លៃ ដែលបានចុះក្នុងបញ្ជីសេវាជំនួយរបស់អ្នក។ (TTY: 711)។

**ATENSHUN:** Kunjka 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 **CHamoru (Chamorro)**, guaha setbisio siha para hãgu ni’ mandibãtdi, i setbision fino’ pat lengguãhi yan fina’uma’espiha gi otro na manera siha, taiguihi i para mana’dãngkolo i inemprenta. Kãlle **1-866-260-2723** para Planãn Medikú, **1-800-638-3120** para Planãn Visión, **1-877-816-3596** para Planãn Dental, pat kãlle i númeru gratut na teleponu na esta pá’go gi kãtta 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 پزشک خود در زمان ویزیت یا 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 دسترس شما هستند. برای برنامه‌های پزشکی با شماره

1-866-260-2723 و برای طرح چشم پزشکی با شماره 1-800-638-3120 و برای طرح دندانپزشکی با شماره 1-877-816-3596، یا با (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط تلفن 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).

**ध्यान आपो:** तमे तमारी मुलाकात समये अथवा अमारी साथे तमारा डोकटर साथे वात करवा माटे दुभाषिया मेजवी शके छे. जे तमे गुजराती (**Gujarati**), बोली छे, तो मइत भाषा सहायता सेवाओ अने अन्य फ़ॉर्मेटमां मइत संचार, जेम के मोटी प्रिन्ट, तमारा माटे उपलब्ध छे. मेडिकल प्लान माटे **1-866-260-2723**, विज़न प्लान माटे **1-800-638-3120**, डेन्टल प्लान माटे **1-877-816-3596** पर कोल करो अथवा तमारा सकय आइडी कार्ड पर सूचिबद्ध टोल-फ्री फ़ोन नंबर पर कोल करो. (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 kominikasyon gratis nan lòt fòm, 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, डेंटल 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 txuas 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).

**ATENsION:** Makaalaka iti interpreter a makisarita kadakami wenna iti doktormo iti oras ti appointment-mo. No makasaoka iti **Ilocano (Ilocano)**, makaalaka iti libre a tulong iti lengguahe 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, wenna tawagam ti libre a numero ti telepono 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可能です。あなたが**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**までお電話いただくか、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).

**ໝາຍເຫດ:** ທ່ານສາມາດຂໍນາຍແບບພາສາເພື່ອເວົ້າກັບທ່ານໝໍໃນເວລາທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ **ພາສາລາວ (Lao)**, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ ແລະ ການສື່ສານພຣິໃນຮູບແບບອື່ນໆ, ເຊັ່ນ: ການພິມຂະໜາດ ໃຫຍ່, ແມ່ນມີໃຫ້ທ່ານ. ໂທ **1-866-260-2723** ສໍາລັບແຜນການທາງການແພດ, **1-800-638-3120** ສໍາລັບແຜນການທາງສາຍຕາ, **1-877-816-3596** ສໍາລັບແຜນການທາງແຂ້ວ, ຫຼື ໂທຫາເບີໂທພຣິທີ່ລະບຸໄວ້ໃນບັດປະຈໍາຕົວສະມາຊິກຂອງທ່ານ.(TTY: 711).

**SHOOH:** Nánihoot'áanii góne' ne'azee' íl'íní bich'í' yáni'ti' doodago nihí nihich'í' yáni'ti'go ata' halne'í'á' naayilt'eehgo bíighah. **Diné (Navajo)** bizaad bee yáni'ti'to, t'áá' jiik'eh saad bee áka'e'eyeed bee áka'anída'ow'í' dóó' t'áá' jiik'eh nááná'lahgo át'éeego bee hada'dilyaaígíí' bee ahít hane', díí nitsaago bik'e'ashchíní, ná dahólq. Ats'íis Nánél'jijh Bee Hada'dít'éhí biniiyé kohjí' **1-866-260-2723** hodílnih, Anáá' Bee Hoot'íní Bee Hada'dít'éhí biniiyé kohjí' **1-800-638-3120** hodílnih, Awoo' Bee Hada'dít'éhí biniiyé kóhjí' **1-877-816-3596** hodílnih, doodago bee nit'ha'dít'éhí ninaaltsoos nit'izí' bee nééhóziní ID baqah t'áá' jiik'eh námbóo bee dahane'í' biká'ígíí' bee hodílnih. (TTY: 711).

**ध्यान दिनुहोस्:** तपाईंले आफ्नो अपोइन्टमेन्टको समयमा वा हामीसँग आफ्नो डाक्टरसँग कुरा गर्न दोभाषे लिन सक्नुहुन्छ। तपाईं **नेपाली (Nepali)** बोलुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र ठूलो अक्षर जस्ता अन्य ढाँचाहरूमा निःशुल्क सञ्चार सेवाहरू तपाईंको लागि उपलब्ध छन्। चिकित्सा योजनाहरूको लागि **1-866-260-2723** भिजन 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)

**WICHDICH:** Du darfscht en Interpreter griege fer schwetze mit dei Dokter an dei Appointment odder mit uns. Wann du **Deitsch (Pennsylvania Dutch)** schwetzsch un brauchsch 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).

**ਧਿਆਨ ਦਿਓ:** ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਮੁਫਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਮੈਡੀਕਲ ਯੋਜਨਾਵਾਂ ਲਈ **1-866-260-2723**, ਵਿਜ਼ਨ 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 TTY: 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 tagata. (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, ayaa 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 Pangingin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tumawag nang libre sa numero ng telepono na nakalista sa iyong ID card ng miyembro. (TTY: 711).

**หมายเหตุ:** คุณสามารถขอคำปรึกษาเกี่ยวกับแพทย์ของคุณได้ในเวลาที่คุณนัดหมายหรือกับเรา หากคุณพูดภาษาไทย (**Thai**) เรายินดีให้บริการช่วยเหลือด้านภาษาและการสื่อสารในรูปแบบอื่นๆ เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่โดยไม่คิดค่าใช้จ่าย โทร **1-866-260-2723** สำหรับการวางแผนทางการแพทย์ **1-800-638-3120** สำหรับการวางแผนทันตกรรม **1-877-816-3596** สำหรับการวางแผนทันตกรรม หรือโทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ในบัตรประจำตัวสมาชิกของคุณ (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 ТТУ: 711).

**توجہ فرمائیں:** آپ اپنی ملاقات کے وقت یا ہمارے ساتھ اپنے ڈاکٹر سے بات کرنے کے لیے مترجم حاصل کر سکتے ہیں۔ اگر آپ اردو (Urdu) بولتے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیٹس مثلاً بڑے پرنٹ میں مفت مواصلات آپ کے لیے دستیاب ہیں۔ میڈیکل پلانز کے لیے **1-866-260-2723** پر، ویژن پلانز کے لیے **1-800-638-3120**، ڈینٹل پلانز کے لیے **1-877-816-3596** پر کال کریں، یا (TTY: 711) ا

**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 Nhân 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).