



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit [Member Tools | Why UHC Florida](#). 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/](http://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 <u>deductible</u> ?                             | <u>Network</u> : \$0 Individual / \$0 Family<br><u>Non-Network</u> : Not Covered                                                                                                                | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. This <u>plan</u> does not have a <u>deductible</u> .                                                                                                                                       | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                                                                                                                                                          |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                                                             | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | Medical: Individual \$1,500 / Family \$3,000.<br><u>Network</u> : \$10,150 Individual / \$20,300 Family<br><u>Non-Network</u> : <b>Not Covered</b><br>Per calendar year. This includes Pharmacy | 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 <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, 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</u> limit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="#">Search for a Provider   Why UHC Florida</a> or call 1-866-633-2446 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 out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>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                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                      |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copay</u> per visit                  | Not Covered                                        | Virtual visits (Telehealth) - \$20 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . Designated Virtual Care INN - No charge<br>No virtual coverage out-of- <u>network</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. |
|                                                               | <u>Specialist</u> visit                          | \$40 <u>copay</u> per visit                  | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |
|                                                               | <u>Preventive care/screening/Immunization</u>    | No Charge                                    | Not Covered                                        | 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. No coverage out-of- <u>network</u> .                                                                                                                                         |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                    | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |
|                                                               | Imaging (CT/PET scans, MRIs)                     | No Charge                                    | Not Covered                                        | Prior Authorization required                                                                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                                                                                                                                                                                                                                                                                      | Services You May Need                          | What You Will Pay                                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                           |                                                | Network Provider<br>(You will pay the least)                                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="https://welcome.optumrx.com/s/ofdms/prescription-drug-list">prescription drug coverage</a> is available at <a href="https://welcome.optumrx.com/s/ofdms/prescription-drug-list">welcome.optumrx.com/s/ofdms/prescription-drug-list</a> | Tier 1 – Generic Drugs                         | \$7 <u>copay</u> / prescription (retail) 30-day supply; \$14 <u>copay</u> / prescription (participating retail pharmacy or mail order) 90-day supply.   | Retail:<br>Not Covered.                            | Retail coverage applies up to a 30-day supply. <u>Plan</u> covers up to a 90-day supply via mail order and up to a 90-day supply of maintenance drugs via participating retail pharmacy. Certain drugs may be subject to quantity limits. Brand additional charge may also apply.<br><br>Certain drugs may be subject to quantity limits. Brand additional charge may also apply. |
|                                                                                                                                                                                                                                                                                                                                           | Tier 2 – Preferred brand drugs                 | \$30 <u>copay</u> / prescription (retail) 30-day supply; \$60 <u>copay</u> / prescription (participating retail pharmacy or mail order) 90-day supply.  | Retail:<br>Not Covered                             |                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                           | Tier 3 – Non-Preferred Brand Drugs             | \$50 <u>copay</u> / prescription (retail) 30-day supply; \$100 <u>copay</u> / prescription (participating retail pharmacy or mail order) 90-day supply. | Retail:<br>Not Covered                             |                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                           | Tier 4 – Specialty drugs                       | Not Applicable                                                                                                                                          | Not Applicable                                     |                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center) | No Charge                                                                                                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                           | Physician/surgeon fees                         | No Charge                                                                                                                                               | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                                            | <u>Emergency room care</u>                     | \$100 <u>copay</u> per visit                                                                                                                            | \$100 <u>copay</u> per visit                       | \$100 <u>copay</u> per visit applies (waived if admitted). Prior Authorization is required if admitted to a non- <u>network</u> hospital and is the responsibility of the <u>network provider</u> . You will not be penalized for services due to lack of prior authorization.                                                                                                    |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                           |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                  |
|                                                                                  | <u>Emergency medical transportation</u>   | No Charge                                    | *20% <u>coinsurance</u>                            | None                                                                                                                                                                                                             |
|                                                                                  | <u>Urgent care</u>                        | \$25 <u>copay</u> per visit                  | Not Covered                                        | None                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | \$250 <u>copay</u> per visit                 | Not Covered                                        | Prior authorization required. Your benefits/services may be denied.                                                                                                                                              |
|                                                                                  | Physician/surgeon fees                    | No Charge                                    | Not Covered                                        | None                                                                                                                                                                                                             |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$20 <u>copay</u> per visit                  | Not Covered                                        | None                                                                                                                                                                                                             |
|                                                                                  | Inpatient services                        | \$250 <u>copay</u> per visit                 | Not Covered                                        | None                                                                                                                                                                                                             |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$40 <u>copay</u> initial visit only         | Not Covered                                        | Routine prenatal care is covered at No charge after first visit. PCP and <u>Specialist copay</u> will apply based on <u>provider status</u> .                                                                    |
|                                                                                  | Childbirth/delivery professional services | No Charge                                    | Not Covered                                        |                                                                                                                                                                                                                  |
|                                                                                  | Childbirth/delivery facility services     | \$250 <u>copay</u> per visit                 | Not Covered                                        | None                                                                                                                                                                                                             |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | No Charge                                    | Not Covered                                        | Approved treatment <u>plan</u> required.                                                                                                                                                                         |
|                                                                                  | <u>Rehabilitation services</u>            | \$40 <u>copay</u> per visit                  | Not Covered                                        | \$40 <u>Specialist copay</u> applies. Physical, speech, manipulative care, and occupational therapy to treat injuries is limited to 60 visits per injury.                                                        |
|                                                                                  | <u>Habilitative services</u>              | \$40 <u>copay</u> per visit                  | Not Covered                                        | Habilitation: Habilitative occupational therapy is limited to <u>home health care</u> , <u>hospice care</u> , treatment of Autism Spectrum Disorder, treatment of Developmental Disabilities, and Down syndrome. |
|                                                                                  | <u>Skilled nursing care</u>               | No Charge                                    | Not Covered                                        | Limited to 60 days per calendar year (combined with inpatient rehabilitation)                                                                                                                                    |
|                                                                                  | <u>Durable medical equipment</u>          | No Charge                                    | Not Covered                                        | Prosthetics are limited to a purchase of each type of device every three years. Surgical boots/shoe are not covered.                                                                                             |
|                                                                                  |                                           |                                              |                                                    |                                                                                                                                                                                                                  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                              |
|----------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                     |
|                                        | <u>Hospice services</u>    | No Charge                                    | Not Covered                                        | Benefits are limited to 210 days during the entire period of time you are covered under the Policy. |
| If your child needs dental or eye care | Children's eye exam        | No Charge                                    | Not Covered                                        | None                                                                                                |
|                                        | Children's glasses         | Not Covered                                  | Not Covered                                        | No coverage for Children's glasses.                                                                 |
|                                        | Children's dental check-up | Not Covered                                  | Not Covered                                        | No coverage for Children's Dental check-up.                                                         |

#### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                                          |                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care</li> </ul>                                                           | <ul style="list-style-type: none"> <li>Glasses</li> <li>Hearing Aids</li> <li>Long-term care</li> </ul>  | <ul style="list-style-type: none"> <li>Non-emergency care when travelling outside - the U.S.</li> <li>Private duty nursing</li> <li>Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                                                                                                          |                                                                                                                                                                     |
| <ul style="list-style-type: none"> <li>Chiropractic (Manipulative care)</li> </ul>                                                                                     | <ul style="list-style-type: none"> <li>Foot care (when associated with treatment of diabetes)</li> </ul> | <ul style="list-style-type: none"> <li>Routine vision exam (i.e. refraction)</li> </ul>                                                                             |

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: the Member Service number listed on the back of your ID card or [myuhc.com](http://myuhc.com).

Additionally, a consumer assistance program may help you file your appeal. Contact [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

**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 the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-633-2446.

*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> | \$0   |
| ■ <u>Specialist</u> copay                     | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | \$250 |
| ■ Other <u>coinsurance</u>                    | 0%    |

#### This EXAMPLE event includes services like:

Specialist office visits (*pre-natal 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> |
|---------------------------|-----------------|

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

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$290        |
| <u>Coinsurance</u>                | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Peg would pay is</b> | <b>\$290</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> | \$0   |
| ■ <u>Specialist</u> copay                     | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | \$250 |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$500        |
| <u>Coinsurance</u>                | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$500</b> |

### Mia's Simple Fracture

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0   |
| ■ <u>Specialist</u> copay                     | \$40  |
| ■ Hospital (facility) <u>coinsurance</u>      | \$250 |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$290        |
| <u>Coinsurance</u>                | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$290</b> |

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](mailto: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.

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**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.

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PAUNA\VA: Kungnagsasalita 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).

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ATANSYON:Si wpale **Kreyol ayisyen (Haitian Creole)**, ou kapab benefisye sevis ki gratis pou ede w nan lang paw. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez **franc;ais (French)**, des services d'aidelinguistique vous soot proposes gratuitement. Veuillez appeler le numero sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jezeli m6,visz po **polsku (Polish)**, udost pnilismy darmoweuslugi tlumacza. Prosimy zadzwonicpod bezplatny numer podanyw niniejszym Zesta,vieniu s,viadczen i refundacji (Summary of Benefits and Coverage, SBC).

ATEN<;AO:Se voce fala **portugues (Portuguese)**, contate o servic;o de assistencia de idiomas gratuito. Ligue para o numero gratuito listado neste Resumo de Beneficios 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 ii numero verde indicato all'intemo di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnenkostenlos sprachliche Hilfsdienstleistungen zur Verfung. Bitterufen Sie die in dieser Zusammenfassung der Leistungen und Kostenubemahmen (Summary of Benefits and Coverage, SBC) angegebene gebuhrenfreie Rufnummer an.

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CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais !us pub dawbrau koj. Thov hu rau tus xov tooj hu dawb teevmuaj  
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Coverage, SBC)12:'1

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam.  
Maidawatnga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti unegna daytoy nga Dagup dagiti Benipisyo ken  
Pannakasakup (Summary of Benefits and Coverage, SBC).

Dff BAA'A.KONINIZIN **Dine (Navajo)** bizaad bee yanilti'go, saad bee aka'anida'awo'igii, t'aa jiik'eh, bee na'ah66t'i'. T'aa shqqdi Naaltsoos  
Bee 'Aa'ahayani d66 Bee 'Ak'e'asti' Bee Baa Hane'i (Summary of Benefits and Coverage, SBC) biyi' t'aa jiik'ehgo beesh bee hane'i bika'igii  
bee hodiilnih.

OGO\ V: 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).