



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, [www.healthplanofnevada.com](http://www.healthplanofnevada.com). 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 1-800-777-1840 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$5,450 / Member and \$10,900 / Family                                                                                                                                                               | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                              |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> , urgent care and outpatient office visits are covered before you meet your <u>deductible</u> .                                                                          | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | Yes. \$1,500/Insured, \$3,000/Family <u>deductible</u> for Tiers 3 and 4 for <u>prescription drug coverage</u> . 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 <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$9,700 / Member and \$19,400 / Family                                                                                                                                                               | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | Penalties for not obtaining any required <u>prior authorization</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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.healthplanofnevada.com/Member/Doctor-or-Provider">www.healthplanofnevada.com/Member/Doctor-or-Provider</a> or call 1-800-777-1840 for a list of <u>Plan 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 charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | Yes                                                                                                                                                                                                  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                    |                                                          | HMO Provider<br>(You will pay the least)                                                                                                               | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                         |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                      | Primary care visit to treat an injury or illness         | \$40 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                                             | Not Covered                                  | None                                                                                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Specialist</u> visit                                  | \$80 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                                             | Not Covered                                  | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                         |
|                                                                                                                                                                                                                    | <u>Preventive care</u> / <u>screening</u> / immunization | No charge                                                                                                                                              | Not Covered                                  | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                          | <u>Diagnostic test</u> (x-ray, blood work)               | X-ray: 40% <u>coinsurance</u><br>Lab: \$25 <u>copay</u> /service; <u>deductible</u> does not apply                                                     | Not Covered                                  | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                         |
|                                                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                             | 40% <u>coinsurance</u>                                                                                                                                 | Not Covered                                  |                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.healthplanofnevada.com">www.healthplanofnevada.com</a> | Tier 1                                                   | \$25 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply \$62.50 <u>copay</u> /prescription (mail); <u>deductible</u> does not apply | Not Covered                                  | Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if <u>prior authorization</u> or step therapy is not obtained.                |
|                                                                                                                                                                                                                    | Tier 2                                                   | \$50 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply \$125 <u>copay</u> /prescription (mail); <u>deductible</u> does not apply   | Not Covered                                  |                                                                                                                                                                                         |
|                                                                                                                                                                                                                    | Tier 3                                                   | 50% <u>coinsurance</u> (retail)<br>50% <u>coinsurance</u> (mail)                                                                                       | Not Covered                                  |                                                                                                                                                                                         |
|                                                                                                                                                                                                                    | Tier 4                                                   | 50% <u>coinsurance</u> (retail)<br>50% <u>coinsurance</u> (mail)                                                                                       | Not Covered                                  |                                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center)           | 40% <u>coinsurance</u>                                                                                                                                 | Not Covered                                  | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                         |
|                                                                                                                                                                                                                    | Physician/surgeon fees                                   | 40% <u>coinsurance</u>                                                                                                                                 | Not Covered                                  |                                                                                                                                                                                         |

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

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                    |                                                                                      | Limitations, Exceptions & Other Important Information                                                                                                                                                                  |
|---------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | HMO Provider<br>(You will pay the least)                                             | Non-Plan Provider<br>(You will pay the most)                                         |                                                                                                                                                                                                                        |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | ER Facility: \$1500<br><u>copay/visit</u><br>ER Physician: \$0<br><u>copay/visit</u> | ER Facility: \$1500<br><u>copay/visit</u><br>ER Physician: \$0<br><u>copay/visit</u> | You may be <u>balance billed</u> from <u>Non-Plan Providers</u> . <u>Copay</u> applies prior to the <u>deductible</u> .                                                                                                |
|                                                                           | <u>Emergency medical transportation</u>   | 40% <u>coinsurance</u>                                                               | 40% <u>coinsurance</u>                                                               | You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .                                                                                                                                                      |
|                                                                           | <u>Urgent care</u>                        | \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply                           | \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply                           | You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 40% <u>coinsurance</u>                                                               | Not Covered                                                                          | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                        |
|                                                                           | Physician/surgeon fees                    | 40% <u>coinsurance</u>                                                               | Not Covered                                                                          |                                                                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 <u>copay/visit</u> ; <u>deductible</u> does not apply                           | Not Covered                                                                          | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                        |
|                                                                           | Inpatient services                        | 40% <u>coinsurance</u>                                                               | Not Covered                                                                          |                                                                                                                                                                                                                        |
| If you are pregnant                                                       | Office visits                             | No charge                                                                            | Not Covered                                                                          | Routine prenatal care obtained from a <u>Plan Provider</u> is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).                                           |
|                                                                           | Childbirth/delivery professional services | 40% <u>coinsurance</u>                                                               | Not Covered                                                                          | Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Member pays for cost of services if <u>prior authorization</u> is not obtained. |
|                                                                           | Childbirth/delivery facility services     | 40% <u>coinsurance</u>                                                               | Not Covered                                                                          | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                        |

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

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                                                         |                                              | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | HMO Provider<br>(You will pay the least)                                                                                  | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                          |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$40 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                | Not Covered                                  | Does not include <u>Specialty Prescription Drugs</u> . Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                                                   |
|                                                                | <u>Rehabilitation services</u>   | 40% <u>coinsurance</u>                                                                                                    | Not Covered                                  | Coverage is limited to a combined Inpatient and Outpatient benefit of 120 days/visits per year. Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                          |
|                                                                | <u>Habilitation services</u>     | 40% <u>coinsurance</u>                                                                                                    | Not Covered                                  | Coverage is limited to a combined Inpatient and Outpatient benefit of 120 days/visits per year. Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                          |
|                                                                | <u>Skilled nursing care</u>      | 40% <u>coinsurance</u>                                                                                                    | Not Covered                                  | Coverage is limited to 100 days. Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                                                                         |
|                                                                | <u>Durable medical equipment</u> | \$200 <u>copay</u> /device; <u>deductible</u> does not apply or 50% <u>coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                  | Whichever <u>DME copayment</u> is less applies. Monthly rental or purchase at HPN's option. Coverage is limited to a single purchase of a type of <u>DME</u> , including repair and replacement, once every 3 years. Member pays for the cost of services if <u>prior authorization</u> is not obtained. |
|                                                                | <u>Hospice services</u>          | 40% <u>coinsurance</u>                                                                                                    | Not Covered                                  | Member pays for cost of services if <u>prior authorization</u> is not obtained.                                                                                                                                                                                                                          |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                                                                 | Not Covered                                  | One vision exam, glasses and frames will be covered once every Calendar Year for Members up to age 19. Please refer to your <u>plan</u> documents for more information.                                                                                                                                  |
|                                                                | Children's glasses               | No charge                                                                                                                 | Not Covered                                  |                                                                                                                                                                                                                                                                                                          |
|                                                                | Children's dental check-up       | No charge                                                                                                                 | Not Covered                                  | Routine Periodic exams are limited to 1 every 6 months for Members up to age 19 per Calendar Year. Please refer to your <u>plan</u> documents for more information.                                                                                                                                      |

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>• Abortion (except for rape, incest, life at risk)</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>                | <ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

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

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

- Bariatric surgery - One (1) per Lifetime
- Hearing aids - One (1) every three (3) years (including repair/replace)
- Private-duty nursing
- Chiropractic care - 20 visits per calendar year
- Limited infertility treatment

**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 Nevada Department of Insurance at 888-872-3234 or [www.doi.nv.gov](http://www.doi.nv.gov) or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

<https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

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 Nevada Division of Insurance at 1-888-872-3234 or <http://www.doi.state.nv.us>.

**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

**Language Access Services:**

Spanish (Español): Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Tagalog (Tagalog): Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

Chinese (中文): 若需要中文协助, 请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

*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> | \$5,450.00 |
| ■ <u>Specialist copayment</u>                 | \$80.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 40%        |
| ■ <u>Other coinsurance</u>                    | 40%        |

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 | \$12,700.00 |
|--------------------|-------------|

In this example, Peg would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|                    |            |
|--------------------|------------|
| <u>Deductibles</u> | \$5,450.00 |
| <u>Copayments</u>  | \$300.00   |
| <u>Coinsurance</u> | \$2,400.00 |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |         |
|----------------------|---------|
| Limits or exclusions | \$80.00 |
|----------------------|---------|

|                            |            |
|----------------------------|------------|
| The total Peg would pay is | \$8,230.00 |
|----------------------------|------------|

### 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> | \$5,450.00 |
| ■ <u>Specialist copayment</u>                 | \$80.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 40%        |
| ■ <u>Other copayment</u>                      | \$25.00    |

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 | \$5,600.00 |
|--------------------|------------|

In this example, Joe would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|                    |            |
|--------------------|------------|
| <u>Deductibles</u> | \$0.00     |
| <u>Copayments</u>  | \$1,400.00 |
| <u>Coinsurance</u> | \$0.00     |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |         |
|----------------------|---------|
| Limits or exclusions | \$40.00 |
|----------------------|---------|

|                            |            |
|----------------------------|------------|
| The total Joe would pay is | \$1,440.00 |
|----------------------------|------------|

### Mia's Simple Fracture

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

|                                               |            |
|-----------------------------------------------|------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,450.00 |
| ■ <u>Specialist copayment</u>                 | \$80.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 40%        |
| ■ <u>Other coinsurance</u>                    | 40%        |

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 | \$2,800.00 |
|--------------------|------------|

In this example, Mia would pay:

| Cost Sharing |  |
|--------------|--|
|--------------|--|

|                    |            |
|--------------------|------------|
| <u>Deductibles</u> | \$1,800.00 |
| <u>Copayments</u>  | \$600.00   |
| <u>Coinsurance</u> | \$20.00    |

| What isn't covered |  |
|--------------------|--|
|--------------------|--|

|                      |        |
|----------------------|--------|
| Limits or exclusions | \$0.00 |
|----------------------|--------|

|                            |            |
|----------------------------|------------|
| The total Mia would pay is | \$2,420.00 |
|----------------------------|------------|

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



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 phone number listed within your Summary of Benefits and Coverage (SBC).

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 phone number listed within your Summary of Benefits and Coverage (SBC).

**English:** You have the right to get help and information in your language at no cost. To request an interpreter, call the phone number listed within this Summary of Benefits and Coverage (SBC).

This letter is also available in other formats like large print. To request the document in another format, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

**Español (Spanish):** Usted tiene derecho a recibir ayuda e información en su idioma sin costo. Para pedir un intérprete, llame al número de teléfono que figura en este Resumen de Beneficios y Cobertura.

**Tagalog (Tagalog):** May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang libre. Upang humiling ng interpreter, tawagan ang numero ng telepono na nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

**繁體中文 (Chinese):**

您有權利以您的母語免費取得協助和資訊。若需申請口譯服務，請打本福利摘要 (SBC) 內含的電話號碼。

**한국어(Korean):** 귀하는 무료로 귀하의 언어를 통해 도움 및 정보를 받으실 권리가 있습니다. 통역사를 요청하시려면 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 전화번호로 전화하십시오.

**Tiếng Việt (Vietnamese):** Quý vị có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu thông dịch viên, hãy gọi số điện thoại được liệt kê trong Tóm tắt quyền lợi và khoản dài thọ (Summary of Benefits and Coverage, SBC) này.

**አማርኛ(Amharic):-** የሰላም ወጪ ለርዳታ ወረዳ የሚገኝ ወብታ ለሰዎች፡ ለስተርጓሚ ለመጠየቅ፡ በዚህ Summary of Benefits and Coverage/የጥቅምጥቅምችና የሕፃን ማጠቃለያ (SBC) ውስጥ የተዘረዘረው የፋልፎን ርዕሰ ደረጃ፡፡

### ภาษาไทย (Thai):

คุณมีสิทธิรับความช่วยเหลือและข้อมูลเป็นภาษาของตนเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ

ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร

"สาระสำคัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (Summary of Benefits and Coverage หรือ SBC)" นี้

### 日本語 (Japanese):

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されている電話番号にお電話ください。

العربية (Arabic): لديك الحق في الحصول على المساعدة بلسانك دون تكلفة. لطلب مترجم، اتصل برقم الهاتف المدرج في موزع المزايا والتغطية هنا (SBC).

**Русский (Russian):** Вы вправе получить помощь и информацию на родном языке без дополнительного оплаты. Чтобы заказать услуги переводчика, обращайтесь по номеру, указанному в данном Обзоре льгот и страхового покрытия (Summary of Benefits and Coverage, SBC)

**Français (French):** Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander l'aide d'un interprète, veuillez appeler le numéro de téléphone figurant dans ce Sommaire des prestations et de la couverture.

فارسی (Persian): شما حق دارید که راهنمایی و اطلاعات را به طور رایگان به زبان خودتان دریافت کنید. برای درخواست مترجم شفاهی، با شماره ای که در این خلاصه مزایا و پوشش (SBC) قید شده تماس بگیرید.

**Gagana fa'a Sāmoa (Samoan):** E iai lau aia tatau e maua ai le fesoasoani ma faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tagata faailili, telefoni i le numera o lisi atu i totonu o lenei Ototoaga o Faamanuiaga ma le Kavaina (SBC).

**Deutsch (German):** Sie haben das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Zur Anforderung eines Dolmetschers wenden Sie sich bitte telefonisch an die in dieser Zusammenfassung der Leistungen und des Versicherungsschutzes aufgeführte Rufnummer.

**Ilokano (Ilocano):** Addaan ka ti karbengan nga makaala iti tulong ken impormasion ayan iti lenguahem nga awan bayad na. Tapno agkidaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Pannakasakup (SBC).