UnitedHealthcare Oxford

Medical Plan Summary/Rates

Company Name: Healthy New Yrok
NY - 11354
# of Eligibles: 3
SIC Code: 5199

Broker: NELSON LAI
Broker Phone: (212) 484-9888

UHC Sales Rep: Munmeet Singh
UHC Sales Rep Phone: N/A

Effective Date: 01/01/2023
Creation Date: 12/9/2022, 5:21:08 PM EST

Medical coverage minimum participation for NY = 60%											
License Plan Name (Customized Plan Name)	Total Monthly Health Cost $	Deductible		Coinsurance	Out of Pocket		Copay	PCP Required	Prescription Drugs		Composite Rates
		Individual (In/Out) $	Family (In/Out) $	(In/Out) %	Individual (In/Out) $	Family (In/Out) $	PCP/Spec[3] $		Ded $	T1/T2/T3/T4 $	
HNY											
NY G MTRO GT 25/40/600/80 EPO HNY 23 Core Rewards	2,520.06	600 / N/A	1,200 / N/A	80 / N/A	4,750	9,500	$25 after deductible / $40 after deductible	Yes	$0.00	$10/$35/$70	EO: $840.02 ES: $1,680.03 EC: $1,428.03 EF: $2,394.05

[3]Refer to the benefit summary for the full PCP and Specialist cost share information

UnitedHealthcare Oxford

Employer Profile

Company Name: Healthy New Yrok
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Employer Information

State	New York
Zip Code	11354
Number of Locations	1
SIC Code - Description	5199 - nondurable goods, not elsewhere classified
Average Total Number of Employees / FTE	3
Total Number of Eligible Employees	3
Total Number of Applying Active	3
Total Number of Applying COBRA	0
Total Number of Out of Area Employees	0
Primary Contact Name	Not Provided
Primary Contact Email	Not Provided

Member Counts

Total Employees	3
Total Dependents	0
Total Members	3

UnitedHealthcare Oxford

Employee Census Details

Company Name: Healthy New Yrok
NY - 11354
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Census

Census Coverage Levels

First & Last Name	Relationship	Gender	DOB	Age	Status	Employee Class	Salary	Out of Area	M
	Employee				Active	N/A	$0.00	No	EE
	Employee				Active	N/A	$0.00	No	EE
	Employee				Active	N/A	$0.00	No	EE

KEY: M - Medical
EE - Employee Only

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Medical Plan Name	NY G MTRO GT 25/40/600/80 EPO HNY 23	
UHC Rewards Level	Core Rewards	
Rx Option	$0D $10/$35/$70	
Product Type	Metro	
Metallic Level	Gold	
License Type	HNY	
	In-Network	Out-of-Network
Medical Deductible/Out of Pocket		
Individual/Family Deductible	$600.00 / $1,200.00	Does Not Apply
Individual/Family Out of Pocket	$4,750.00 / $9,500.00	Does Not Apply
Co-insurance (Plan Pays)		
Hospital Co-insurance	80%	N/A
Visit to Provider Office		
Primary Care Visit Co-payment[4]	$25 after deductible	Does Not Apply
Specialist Visit Co-payment[4]	$40 after deductible	Does Not Apply
Referral Required	See Benefit Summary	Does Not Apply
PCP Required	Yes	Does Not Apply
Visit to Urgent Care and ER		
Emergency Room	$150 after deductible	$150 after deductible
Urgent Care	$60 after deductible	N/A
Pharmacy RX		
RX Deductible	$0.00	
tier1	$10	
tier2	$35	
tier3	$70	
tier4		
Premium (4-Tier Composite Rating)		
Employee Only (3)	$2,520.06	
Employee + Spouse (0)	$0.00	
Employee + Child(ren) (0)	$0.00	
Family (0)	$0.00	
Total Monthly Premium	2520.06	

[4]Refer to the benefit summary for the full PCP and Specialist cost share information

UnitedHealthcare Oxford

Medical Census and Rate Details

Company Name: Healthy New Yrok
NY - 11354
# of Eligibles: 3
SIC Code: 5199

Broker: NELSON LAI
Broker Phone: (212) 484-9888

UHC Sales Rep: Munmeet Singh
UHC Sales Rep Phone: N/A

Effective Date: 01/01/2023
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Census Details						Rate Details
Name	*Gender*	*DOB*	*Age*	*Coverage Level*	*OOA*	*NY G MTRO GT 25/40/600/80 EPO HNY 23 Gold Core Rewards*
				Employee Only	No	$840.02
				Employee Only	No	$840.02
				Employee Only	No	$840.02
				Total Monthly Premium		$2,520.06
				Annual Premium		$30,240.72

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1. Provider type varies by region.

2. For Oxford Metro Network EPO HSA plan designs, all innetwork medical and pharmacy services are subject to the innetwork deductible. Once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the option selected at plan inception. No individual enrolled as a couple, parent/family deductible has been met. Each individual enrolled as a couple, parent/child(ren) or family will be capped at his or her individual out-of-pocket limit for covered services within the deductible accumulation period. The remaining family members will continue to accrue until they satisfy their individual out-of-pocket limit or the family out-of-pocket limit is reached.

3. Note: All quotes are based on the census data provided. Approval of coverage and final rates will be based on actual enrollment. Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and UHC/Oxford home office approval as appropriate.

4. This premium includes state and federal taxes and fees, including the Insurer Fee (about 3% of premium) and the Reinsurance Fee (about $1 per member per month) under the Affordable Care Act. These estimates will vary based on renewal date and reinsurance fees.

5. All data as of December 31,2002. This data represents all participating providers except ancillary providers. Dental and alternative medicine are included (~6% of the total without chiropractors who are considered specialists). Providers who are multiply boarded are counted multiple times.

6. Primary care physicians (PCP) include Family Practice, Internal Medicine, Obstetrics-Gynecology and Pediatrics.

7. Plans with non-embedded deductibles reflect family deductible, meaning no individual in the family has satisfied the deductible until the entire family amount has been met. Embedded deductibles mean all individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

8. An additional charge may apply when a prescription drug on a higher tier is dispensed at the member or the member's provider's request, when a chemically equivalent prescription drug is available on a lower tier. The member will have to pay the difference between the cost of the prescription drug n the higher tier and the cost of the prescription drug on the lower tier. The cost difference must be paid in addition to the lower tier copayment or coinsurance. The member is responsible for paying the full cost (the amount the pharmacy charges the member) for any non-covered prescription drug and our contracted rates (our prescription drug cost) will not be available to the member.

9. For Oxford Metro Network EPO plan designs, once the in-network deductible has been satisfied by an individual, the applicable medical coinsurance will apply based on the selected plan. If the individual is enrolled as a couple, parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance will apply based on the selected plan.

10. In 2018, maximum HSA contribution is $3,450 single/$6,900 family. These amounts are subject to change by the IRS and do not include catch-up contributions for subscribers aged 55 and over.

11. Note: For Pharmacy plans with a deductible, the deductible does not apply to Tier 1 medications, with the exception of New York standard pharmacy plans and HSA pharmacy plans.

12. Note: For Pharmacy plans with a deductible, the deductible does not apply to Tier 1 medications, with the exception of New York standard pharmacy plans and HSA pharmacy plans.

13. For Oxford Metro Network Primary Advantage plan designs, once the deductible has been satisfied, the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan. If the individual is enrolled as a couple, parent/children or family and the family deductible is met, then no further deductible is required, and the applicable medical coinsurance and prescription drug copayment will apply based on the selected plan.

UnitedHealthcare insurance Company is located in Hartford, CT; Unimerica Life Insurance Company of New York is located in New York, NY. This premium includes state and federal taxes and fees, including the Insurer Fee (about 3% of premium) and the Reinsurance Fee (about 1% per member per month) under the Affordable Care Act. These estimates will vary based on renewal date and state reinsurance fees.

15. Note: For HSAs, copayments will not apply until after the deductible has been satisfied.

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.myuhc.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/ or call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $600 Individual /$1,200 Family per policy year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $4,750 Individual /$9,500 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-800-444-6222 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

[1]Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc., and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not Covered	Virtual visits (Telehealth) - $25 copay per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	$40 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay per service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$40 copay per service	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	Tier 1	Retail: $10 copay, deductible does not apply Mail-Order: $25 copay, deductible does not apply	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2	Retail: $35 copay, deductible does not apply Mail-Order: $87.50 copay, deductible does not apply	Not Covered	
	Tier 3	Retail: $70 copay, deductible does not apply Mail-Order: $175 copay, deductible does not apply	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per service	Not Covered	None
	Physician/surgeon fees	$100 copay per visit	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	*Network deductible applies.
	Emergency medical transportation	$150 copay per transport	$150 copay per transport	*Network deductible Applies.
	Urgent care	$60 copay per visit	Not Covered	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per admission	Not Covered	None
	Physician/surgeon fees	$100 copay per visit	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit	Not Covered	Network partial hospitalization/intensive outpatient treatment: $25 copay per visit
	Inpatient services	$1,000 copay per admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$100 copay per visit	Not Covered	
	Childbirth/delivery facility services	$1,000 copay per admission	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$25 copay per visit	Not Covered	Limited to 40 visits per policy year.
	Rehabilitation services	$30 copay per outpatient visit	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits.
	Habilitation services	$30 copay per outpatient visit	Not Covered	Limits per policy year: Physical, speech and occupational therapy combined limit 60 visits.
	Skilled nursing care	$1,000 copay per admission	Not Covered	Limited to 200 days per policy year.
	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for DME over $500 or there is no coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	$1,000 copay per admission	Not Covered	Limited to 210 days per policy year (Inpatient & Home Hospice combined).
If your child needs dental or eye care	Children's eye exam	$25 copay per visit	Not Covered	Limited to 1 exam every 12 months. Covered for individuals up to the age of 19.
	Children's glasses	20% coinsurance	Not Covered	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit doesn't cover both. Covered for individuals up to the age of 19.
	Children's dental check-up	$25 copay per visit	Not Covered	Cleanings are covered 2 times per 12 months. Additional limitations may apply. Covered for individuals up to the age of 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic (Manipulative) care
- Hearing Aids
- Infertility Treatment – Cycle limits may apply.

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: www.dfs.ny.gov/index.htm Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565

or 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 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 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: your human resource department, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the New York Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov/index.htm.

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, kwiijigo 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 plan's overall deductible	$600
Specialist copay	$40
Hospital (facility) copay	$1,000
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600
Specialist copay	$40
Hospital (facility) copay	$1,000
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,630**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist copay	$40
Hospital (facility) copay	$1,000
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

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

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).