PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

2023-2024 Student Health Insurance Plan for LIM College

Who is eligible to enroll?

All Full-time Undergraduate and Graduate LIM College Students are automatically enrolled in and billed for the SHIP, unless proof of comparable coverage is furnished. International Students are enrolled in the SHIP on a mandatory basis. Eligible dependents may enroll on a voluntary basis. Eligible Dependents are the student's spouse or domestic partner and dependent children under 26 years of age. See the Who is Covered section of the Certificate of Coverage for the specific requirements needed to meet domestic partner eligibility.

Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right before you enroll. The certificate of coverage provides details of the coverage including benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the College and may be viewed at www.gallagherstudent.com. This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2023-203250-1. The Policy is a Non-Renewable One-Year Term Policy.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-877-220-2401 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare StudentResources

Coverage Dates, Plan Costs and Premium Rates

The Total Cost of the plan noted below includes premium and fees.

Total Plan Cost and Coverage Dates	Annual 8-15-23 to 8-14-24	Fall 8-15-23 to 1-3-24	Spring/Summer 1-4-24 to 8-14-24
Student	$2,250.00	$872.95	$1,377.05
Spouse	$2,250.00	$872.95	$1,377.05
One Child	$2,250.00	$872.95	$1,377.05
Two or More Children	$4,500.00	$1,745.90	$2,754.10
Spouse and Two or More Children	$6,750.00	$2,618.85	$4,131.15

See the information below for the breakdown of premium and fees.

Premium Rates*	Annual Premium**	Fall Premium**	Spring/Summer Premium**
Student	$2,105.62	$816.94	$1,288.68
Spouse	$2,105.62	$816.94	$1,288.68
One Child	$2,105.62	$816.94	$1,288.68
Two or More Children	$4,211.24	$1,633.88	$2,577.36
Spouse and Two or More Children	$6,316.86	$2,450.82	$3,866.04

*The premium is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include the following fees:

- Annual **Service fee of $2.38 for UHC Global administration of the Assistance and Evacuation Benefits.
- Annual **Administrative fee of $8.00 charged by the school you are receiving coverage through which may, for example, cover your school's administrative costs associated with offering this health plan.
- Annual **Service fee of $134.00 charged by or at the direction of the school you are receiving coverage through to cover the costs of services provided by a non-insurer vendor or consultant.

**Note: Fees are prorated for the coverage dates other than annual.

The Member must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Member's premium must be received within 30 days after the coverage expiration date. It is the Member's responsibility to make timely premium payments to avoid a lapse in coverage.

Highlights of the Student Health Insurance Plan Benefits

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 82.160%

In-Network Benefits
In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Choice Plus network. Participating Providers can be found using the following link: UHC Choice Plus

	In Network Participating Provider Member Cost-Share	Out-of-Network Non-Participating Provider Member Cost-Share
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	$350 Per Member, Per Plan Year	$1,000 Per Member, Per Plan Year
Out-of-Pocket Limit *After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.*	$8,700 Per Member, Per Plan Year $17,400 For all Members in a Family, Per Plan Year	$8,700 Per Member, Per Plan Year $17,400 For all Members in a Family, Per Plan Year
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.*	20% of Allowed Amount[1] for Covered Expenses	50% of Allowed Amount[1] for Covered Expenses
Prescription Drugs *UHCP Mail Order Network Pharmacy or Maintenance Drugs from a Designated Retail Pharmacy at 2 times the retail Copay up to a 90-day supply.*	$20 Copayment for Generic Drugs $45 Copayment for Preferred Brand Name Drugs $100 Copayment for Non-Preferred Brand Name Drugs Up to a 30-day supply per prescription not subject to Deductible	50% Coinsurance for Generic Drugs 50% Coinsurance for Brand Name Drugs Up to a 30-day supply per prescription

Preventive Care *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.*	Covered in full	0% of Allowed Amount[1] not subject to Deductible
The following services have per service Copayments *This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.*	Office Visits: $25 Copayment after Deductible Emergency Care in an Emergency Department: $200 Copayment after Deductible	Office Visits: $25 Copayment after Deductible Emergency Care in an Emergency Department: $200 Copayment after Deductible
Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs	Office Visits: $25 Copayment after Deductible Other Outpatient Services: $25 Copayment after Deductible	Office Visits: $25 Copayment after Deductible Other Outpatient Services: $25 Copayment after Deductible
Pediatric Dental and Vision Benefits	Refer to the plan Certificate of Coverage for details (age limits apply).	

[1]The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Providers. The Allowed Amount for Non-Participating Providers will be the lesser of: 1) the Medicare amount; 2) the amount based on cost information from the Centers for Medicare and Medicaid services; 3) The facility or provider's charge; 4) a rate based on information provided by a third-party vendor; or 5) The amount negotiated with the Provider. We reserve the right to negotiate a lower rate with Non-Participating Providers.

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

I. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

J. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

N. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

O. Services With No Charge.
We do not Cover services for which no charge is normally made.

P. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

Q. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

R. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

Highlights of Assistance and Evacuation Benefits

Medical Evacuation and Repatriation

If you are a student insured with this insurance plan, you and your insured Spouse and insured Child(ren) are eligible for Medical Evacuation and Repatriation Benefits. The requirements to receive these services are as follows:

An international Student (whose Home Country is not the United States), and their insured Spouse and insured Child(ren): you are eligible to receive Medical Evacuation and Repatriation Benefits worldwide, except in your home country.

A domestic Student (whose Home Country is the United States), and their insured Spouse and insured child(ren): you are eligible for Medical Evacuation and Repatriation Benefits when 100 miles or more away from your campus address or 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Medical Evacuation and Repatriation Benefits and related services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Assistance Benefits include:

- Emergency Medical Evacuation
- Dispatch of Doctors/Specialists
- Medical Repatriation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Insured Person
- Return of Minor Children
- Repatriation of Mortal Remains

Check your certificate of coverage for details, descriptions and program exclusions and limitations.

Highlights of Services offered by UnitedHealthcare StudentResources

HealthiestYou: 24/7 Doctor Access

Starting on the effective date of your coverage under the student insurance plan, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service. By visiting www.telehealth4students.com, you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor's office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor's office, urgent care facility, or emergency room. As a Member with Student Resources, there is no consultation fee for this service.* Every call with a HealthiestYou doctor is covered 100% during your policy period. You can learn more about this benefit ad how to use it in My Account.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your Student Health Center first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

*Available to Member students and their covered Dependents, age restrictions may apply. If you call prior to the effective date of your coverage under the insurance plan, you will be charged a service fee before being connected to a board-certified physician.

HealthiestYou: Virtual Counselor Access

Starting on the effective date of your coverage under the student insurance plan, you have access to mental health providers through a national virtual counseling service.* Psychiatrists, psychologists and licensed therapists are available to you through a variety of communication methods, including phone and video.

When you sign up, you'll complete a questionnaire, choose your provider and select a date and time for your appointment. Appointments are available 7 days a week. Visits are secure, discreet and confidential, and you have ongoing support with the same provider.

As a Member with Student Resources, there is no consultation fee for this service. Every communication with a provider is covered 100% during your policy period.

*Available to Member students and their covered Dependents; age restrictions may apply, depending on your state.

24/7 Student Support

Members have immediate access to the Student Assistance Program, a service that coordinates counseling services offered by Master's Licensed Clinicians who can provide Members with someone to talk to when everyday issues become overwhelming. More information about these counseling services is available by logging into My Account at www.uhcsr.com/MyAccount.

ID Cards

Digital ID Cards can be downloaded or printed through www.uhcsr.com/MyAccount, where a student can also request delivery of a permanent ID card through the U.S. mail.

Gallagher Student Health Complements

Exclusively from Gallagher Student Health & Special Risk, enrolled students have access to the following menu of products at no additional cost. These plans are not considered insurance products and are not underwritten or administered by UnitedHealthcare Insurance Company of New York. More information is available on your school's page at http://www.gallagherstudent.com/LIM.

Coast to Coast Vision™

Coast to Coast Vision offers discounts on vision benefits to insured students. Coast to Coast's provider network gives students access to over 20,000 independent providers and retail stores nationwide, including For Eyes Optical, Lens Crafters, Pearle Vision, Target Optical, JC Penney Optical and Visionworks locations. There is no waiting period; students can take advantage of the savings immediately. Students can expect 10% to 60% off regular retail pricing on prescription eyeglasses, conventional contact lenses and other retail eyewear items, as well as 10 to 30% off eye examinations and 40 to 50% off the national average on LASIK.

For more information or to access the Coast to Coast Vision™ membership card, visit the 'Discounts' section on your school's page at http://www.gallagherstudent.com/LIM.

UNI-CARE

Maintaining good health extends to taking care of your teeth, gums and mouth. The UNI-CARE savings program provides you with a wide range of dental discount services. UNI-CARE contracts with dentists that agree to charge a negotiated fee to students covered under the Gallagher Student Health Insurance plan. Students must pay for the services received at the time of service to receive the negotiated rate. Savings vary but can be as high as 50% depending on the type of service received and the contracted dentist providing the service. To use the program, students must:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed at https://www.findbestbenefits.com/Home/ProviderSearch .
- Select a participating provider at https://www.findbestbenefits.com/Home/ProviderSearch .
- Give the dental network name to your provider when making your appointment

- Simply present your membership card before getting treatment to be assured the proper discount is applied
- Payment is due at the time of services
- There are no forms to complete and no limit to the number of visits

Full details of the program and contact information for further questions are available at https://www.findbestbenefits.com/Home/ProviderSearch

SilverCloud Behavioral Health

SilverCloud Health offers online, self-guided programs designed for young adults to address anxiety, depression, stress, resilience, or insomnia. Based on cognitive behavioral therapy principles, these self-guided programs are available any time, on any device.

Each module is comprised of an introductory video and quiz, psychoeducational content with examples and personal stories, interactive activities, homework suggestions and summaries.

SilverCloud is accessible to those enrolled in your School's Student Health Insurance Plan. To start on your path to better managing your well-being, visit https://gsh.silvercloudhealth.com/signup/

This Summary Brochure is based on Policy #2023-203250-1.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does 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:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written 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 member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

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 also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᏎᏊᏂᎯᎭᏍᏗ ᎤᎾᏓᏡᏍᎦᏗ ᎤᎾᏓᏈᎬᎢ ᏂᎯ ᎡᏩᏈᏅᎢᏍᏓᏗᏄᎢ ᏂᏓᎬᏩᏈᎾ ᎠᏎᏫᎢ. ᏤᏩᏫ ᎠᏂ ᎶᏏᎳᏰᏎ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla h<u>o</u> chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n’efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
ကျိာ်တၢ်မၤစၢၤအဂီၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိၣ်ဟ့ၣ်အပှ့ၤဘၣ်(ခီလီ)န့ၣ်လီၤ. ဝံသးစူၤဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeḷọk wōṇāān. Jouj im kalḷọk 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziţie, în mod gratuit, servicii de traducere. Vă rugăm să sunaţi la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

Tongan- Fakatonga
‘Oku ‘i ai pē ‘a e sēvesi ki he lea‘ ke tokoni kiate koe pea ‘oku ‘atā ia ma’au ‘o ‘ikai ha totongi. Kātaki ‘o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.

POLICY NUMBER: 2023-203250-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC 2 - 11/20/2023
NOC 2

Summary Brochure:
Updating the customer service number under the "Who can answer questions I have about the plan?" section
FROM:1-800-471-6936
TO: 1-877-220-2401

NOC 1 - 10/19/2023
NOC 1

Certificate:

SOB: Updated the Below line items

Assistive Communication Devices for Autism:

FROM	
20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO	
$25 Copayment after Deductible	$25Copayment after Deductible

Diabetic Equipment, Supplies and Insulin:

FROM	
20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO	
$20 Copayment not subject to Deductible	$20 Copayment not subject to Deductible

Diabetic Education:

FROM	
20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO	
$25 Copayment after Deductible	$25Copayment after Deductible

Allergy Testing and Treatment:

FROM	
$25 Copayment then 20% Coinsurance after Deductible	$25 Copayment then 20% Coinsurance after Deductible

TO
$25 Copayment then after Deductible | $25 Copayment after Deductible

Second Opinions on the Diagnosis of cancer, Surgery and other:
FROM
$25 Copayment then 20% Coinsurance after Deductible | $25 Copayment then 30% Coinsurance after Deductible
TO
$25 Copayment then after Deductible | $25 Copayment after Deductible

Diagnostic Radiology Services:
FROM

Performed in a PCP office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Specialist Office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Freestanding Radiology Facility-	$50 Copayment then 20% Coinsurance after Deductible	$50 Copayment then 30% Coinsurance after Deductible
Performed a outpatient hospital services-	$50 Copayment then 20% Coinsurance after Deductible	$50 Copayment then 30% Coinsurance after Deductible

TO

Performed in a PCP office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Specialist Office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Freestanding Radiology Facility-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed a outpatient hospital services-	$25 Copayment after Deductible	$25 Copayment after Deductible

Cardiac and Pulmonary Rehabilitation:
FROM

Performed in a Specialist Office-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed a outpatient hospital services-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible

TO

Performed in a Specialist Office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed a outpatient hospital services-	$25 Copayment after Deductible	$25 Copayment after Deductible

Dialysis:		
FROM		
Performed in a PCP office-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed in a Specialist Office-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed in a Freestanding Radiology Facility-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed a outpatient hospital services-	$25 Copayment then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO		
Performed in a PCP office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Specialist Office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Freestanding Radiology Facility-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed a outpatient hospital services-	$25 Copayment after Deductible	$25 Copayment after Deductible
Infusion Therapy:		
FROM		
Performed in a PCP office-	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed in a Specialist Office-	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Performed a outpatient hospital services-	20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO		
Performed in a PCP office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed in a Specialist Office-	$25 Copayment after Deductible	$25 Copayment after Deductible
Performed a outpatient hospital services-	$25 Copayment after Deductible	$25 Copayment after Deductible
Maternity and Newborn Care:		
FROM		
Breastfeeding Support, Counseling, and Supplies.....	20% Coinsurance after Deductible	50% Coinsurance after Deductible
TO		
Breastfeeding Support, Counseling, and Supplies.....	Covered in full	30% Coinsurance after Deductible

Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment):

FROM	0% Coinsurance after Deductible	20% Coinsurance after Deductible
TO	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services):

FROM		
All Other Outpatient Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible
TO		
All Other Outpatient Services	$25 Copayment after Deductible	$25 Copayment after Deductible

Outpatient Substance Use Services (including Partial Hospitalization and Intensive Outpatient Program Services):

FROM		
All Other Outpatient Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible
TO		
All Other Outpatient Services	$25 Copayment after Deductible	$25 Copayment after Deductible
Opioid Treatment Programs	Covered in full	$25 Copayment after Deductible

Summary Brochure:

Updated the below line item-

Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs:

FROM		
Other Outpatient Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible
TO:		
Other Outpatient Services	$25 Copayment after Deductible	$25 Copayment after Deductible