



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.uhcsr.com/georgetown or call 1-877-935-5437. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-935-5437 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Select Providers \$0 / (Person) Preferred Providers \$200 / (Person) Preferred Providers \$600 / (Family) Out-of-Network Provider \$250 / (Person) Out-of-Network Provider \$600 / (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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision and categories that specify <u>ded</u> does not apply.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Pediatric Dental \$500, <u>*Prescription Drugs</u> \$150 Ded (Per Policy Year). 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Preferred Providers \$3,000 / (Person) Preferred Providers \$6,000 / (Family) Out-of-Network Provider \$8,000 / (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, <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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.uhcsr.com/georgetown or call 1-877-935-5437 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>Copay</u> /per visit	\$30 <u>Copay</u> /per visit	40% <u>Coins</u>	May not apply when related to surgery or Physiotherapy. Special SHC Benefits: The following benefits will be covered after a \$10 Copayment per visit when provided at the SHC: • Treatment of corns, calluses, bunions. • Hirsutism. • Alopecia. • TB testing when referred by the SHC to LabCorp or Quest. The exclusions will be waived and benefits will be paid for the above mentioned benefits at the SHC. GT Behavioral Health Panel: • The Georgetown Behavioral Health providers will be paid at 100% of the contracted rate after a \$10.00 co-pay per visit, deductible is waived. Nutritional counseling • Nutritional counseling will be covered at 100% of Allowed Amount and Policy Deductible is waived, and is payable only when referred by the SHC and rendered by a Georgetown University Health Education certified nutritionist: The following benefits will be covered as specified in the Schedule of Benefits with a referral from SHC: 1) Sleep disorders; and 2) Allergy testing and
	<u>Specialist</u> visit	\$10 <u>Copay</u> /per visit	20% <u>Coins</u>	40% <u>Coins</u>	

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/georgetown

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
					treatment is covered with a SHC referral. The exclusion will be waived and benefits will be paid for the above mentioned benefits at the SHC. Children are not eligible for coverage at the SHC and the referral requirement does not apply to Dependents under the age of 18. The following benefit will be covered as specified in the Schedule of Benefits with a referral from the designated Georgetown Learning Disability Coordinator: Psychological testing to determine learning disabilities. The Policy Deductible does not apply. Children are not eligible for coverage at the SHC and the referral requirement does not apply to Dependents under the age of 18. The following benefit will be covered at 100% of Allowed Amount with a referral from the SHC: Laboratory Procedures performed at LabCorp or Quest Diagnostics. The Policy Deductible does not apply.
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/georgetown

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.uhcsr.com/pdl	Tier 1 - Your Lowest-Cost Option	Not Available	\$15 <u>Copay</u> per prescription Tier 1	Not Covered	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail Order <u>Network Pharmacy</u> or Preferred 90 Day Retail <u>Network Pharmacy</u> available at a reduced <u>Copay</u> of 2.5 times the monthly retail <u>Copay</u> for a 90-day supply You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> . You may pay more if <u>prior authorization</u> is not obtained. For insulin drugs the total amount of <u>Copays</u> or <u>Coins</u> shall not exceed \$30 for an individual prescription of up to a 30-day supply. Prescription Drug <u>Ded</u> does not apply to insulin drugs. *See Prescription Drug Benefit Endorsement for additional information, including <u>Prescription Drugs</u> that require Prior Authorization.
	Tier 2 - Your Midrange-Cost Option	Not Available	30% <u>Coins</u> per prescription Tier 2	Not Covered	
	Tier 3 - Your Highest-Cost Option	Not Available	30% <u>Coins</u> per prescription Tier 3	Not Covered	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	Physician/surgeon fees	\$10 <u>Copay</u> /per visit	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	Not Available	\$100 <u>Copay</u> /per visit	\$100 <u>Copay</u> /per visit	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	<u>Emergency medical transportation</u>	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	Not Available	\$50 <u>Copay</u> /per visit	\$50 <u>Copay</u> /per visit	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	Physician/surgeon fees	Physician's Visits: No Charge Surgery: Not Available Assistant Surgeon Fees: Not Available Anesthetist Services: Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$10 <u>Copay</u> /per visit Other: No Charge	Office Visits: \$30 <u>Copay</u> /per visit Other: 20% <u>Coins</u>	Office Visits: 40% <u>Coins</u> Other: 40% <u>Coins</u>	_____none_____
	Inpatient services	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you are pregnant	Office visits	Not Available	\$30 <u>Copay</u> /per visit	40% <u>Coins</u>	Cost-sharing does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Physician's Visits: No Charge Surgery: Not Available Assistant	20% <u>Coins</u>	40% <u>Coins</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Surgeon Fees: Not Available Anesthetist Services: Not Available			
	Childbirth/delivery facility services	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	90 visits maximum (Per Policy Year)
	<u>Rehabilitation services</u>	Physiotherapy: \$10 <u>Copay</u> /per visit Inpatient Rehabilitation Facility: Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	\$10 <u>Copay</u> /per visit	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Skilled nursing care</u>	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	Not Available	20% <u>Coins</u>	40% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	Not Available	20% <u>Coins</u> <u>ded</u> does not apply	40% <u>Coins</u> <u>ded</u> does not apply	_____none_____
If your child needs dental or eye care	Children's eye exam	See your plan's Pediatric Vision Benefit Details	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	See your plan's Pediatric Vision Benefit Details	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames:	50% <u>Coins</u> ; <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select Provider	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Tiered <u>Copays</u> from no charge to 40% based on retail cost. <u>ded</u> does not apply		
	Children's dental check-up	See your plan's Pediatric Dental Benefit Details	50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

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 except as specifically provided in the Policy
- Dental care (Adult) except as specifically provided in the Policy
- Long-term care
- Weight loss programs except as specifically provided in the Policy
- Bariatric surgery except as specifically provided in the Policy
- Hearing aids except as specifically provided in the Policy
- Routine eye care (Adult) except as specifically provided in the Policy
- Cosmetic surgery except as specifically provided in the Policy
- Infertility treatment except as specifically provided in the Policy
- Routine foot care except as specifically provided in the Policy

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

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: UnitedHealthcare Student Resources at 1-877-935-5437 and District of Columbia Department of Insurance, Securities, and Banking at 1-202-727-8000 or visit <http://www.disr.washingtondc.gov/disr/site/default.asp>. 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 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: District of Columbia Department of Insurance, Securities, and Banking at 1-202-727-8000 or visit <http://www.disr.washingtondc.gov/disr/site/default.asp>.

Additionally, a consumer assistance program can help you file your appeal, contact DC Office of the Health Care Ombudsman and Bill of Rights at 1-877-685-6391 or visit <http://healthcareombudsman.dc.gov/>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-260-2723.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$2,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,300

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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

Notice of Non-Discrimination

We¹ comply with the applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans (TTY 711).

Civil Right Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, Utah 84130
UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans. (TTY 711).

You can also file a complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

This notice is available at: <https://www.uhc.com/content/dam/uhcdotcom/en/npp/NDN-LA-UHC-StudentResources-EN.pdf>

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

ATTENTION: You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free phone number listed on your ID card. (TTY: 711).

ጥቅሳጥቅሳ፡- በቀጠሮ ይህ ወይም ከእኛ ጋር ሲሆኑ ከሐኪምዎ ጋር ለመነጋገር አስተርጓሚ ማግኘት ይችላሉ። **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎቶች እና ነፃ ግንኙነቶች እንደ ትልቅ ህትመት ባሉ ሌሎች ቅርጾች ለእርስዎ ይገኛሉ። ለህክምና ዕቅዶች ወደ **1-866-260-2723**፣ ለእይታ ዕቅዶች ወደ **1-800-638-3120**፣ ለጥርስ ዕቅዶች ወደ **1-877-816-3596** ይደውሉ ወይም በአባል መታወቂያ ካርድዎ ላይ ወደተዘረዘረው ነፃ የሰልክ ቁጥር ይደውሉ። (TTY: 711)።

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

মনোযোগ দিয়ে শুনুন: আপনার অ্যাপয়েন্টমেন্টের সময় আপনার ডাক্তারের সাথে কথা বলার জন্য বা আমাদের সাথে কথা বলার জন্য আপনি একজন দোভাষী পেতে পারেন। আপনি যদি বাংলা (Bengali) এ কথা বলেন, তাহলে বিনামূল্যের ভাষা সহায়তা পরিষেবা এবং অন্যান্য বিনামূল্যের বিভিন্ন যোগাযোগ পদ্ধতি, যেমন বড় মুদ্রণ, আপনার জন্য উপলব্ধ থাকবে। মেডিকেল প্ল্যানের জন্য কল করুন **1-866-260-2723** নথরে, ভিশন প্ল্যানের জন্য কল করুন **1-800-638-3120** নথরে, ডেন্টাল প্ল্যানের জন্য কল করুন **1-877-816-3596** নথরে, অথবা আপনার সদস্য আইডি কার্ডে টোল-ফ্রি ফোন নথরে কল করুন। (TTY: 711)

ចំណាំ: អ្នកអាចស្នើសុំអ្នកបកប្រែ ដើម្បីទំនាក់ទំនងជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាដែល ឬនិយាយជាមួយយើងខ្ញុំ។ បើសិនអ្នកនិយាយ**កម្ពុជា (Cambodian Mon-Khmer)** មានសេវាជំនួយភាសា ដោយឥតគិតថ្លៃ ការទំនាក់ទំនងដោយឥតគិតថ្លៃ ក្នុងទម្រង់ផ្សេងទៀត ដូចជាអក្សរធំ មានសម្រាប់អ្នក។ សូមហៅទូរសព្ទទៅ **1-866-260-2723** សម្រាប់ការប្រាប់ដឹងស្តីពី **1-800-638-3120** សម្រាប់ការប្រាប់ដឹងទៅភ្នាក់ងារ **1-877-816-3596** សម្រាប់ការប្រាប់ដឹងទៅផ្ទៃក្នុង ឬហៅទូរសព្ទទៅលេខទូរសព្ទដោយមិនគិតថ្លៃ ដែលបានចុះក្នុងប័ណ្ណសមាជិករបស់អ្នក។ (TTY: 711)។

ATENSHUN: Kunika me liye ayu yo interprete para ughul maghal na dokto ya eppunghi me guahu. Gare kapetal Faluwasch (Carolinian), ye toore paliuwal kapetal Faluwasch lane bwe me sew format, ta tipel lane, bwe bwale tepangiyom. Kali **1-866-260-2723** para ughul Lalap ni ughul tipiye, **1-800-638-3120** para ughul Lalap ni tipiye nu mata, **1-877-816-3596** para ughul Lalap ni tipiye nu apapa, o kali ewe kali rerekkepal ni Nuumur ni telepon yeeg listed me ni Kaaret ni meybur ID-mu. (TTY: 711).

ATENSYON: Siña hao humosga un intérprete para kumuentos yan i doktermu gi ora di i konsulta-mu pat yan hame. Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hãgu ni' mandibãtdi, i setbision fino' pat lengguãhi yan fina'uma'espia gi otro na manera siha, taiguihi i para mana'dangcolo i inemprenta. Kålle **1-866-260-2723** para Planån Mediku, **1-800-638-3120** para Planån Visión, **1-877-816-3596** para Planån Dental, pat kålle i número gratut na teleponu na esta på'go gi kãtta ID para miembro -mu. (TTY: 711).

請注意：您可以獲得一位口譯員，在您看診時與您的醫生溝通或平常與我們溝通。如果您說中文 (Chinese)，我們可為您提供免費的語言協助服務與其他溝通格式，例如大字版文件。醫療計劃請致電1-866-260-2723，視力計劃請致電1-800-638-3120，牙科計劃請致電 1-877-816-3596，或撥打您會員卡上所列的免付費電話號碼。(TTY：711)。

توجه: شما می‌توانید یک مترجم برای صحبت با پزشک خود در زمان ویزیت یا برای گفتگو با ما، درخواست کنید. اگر **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و خدمات رایگان ارتباطی در سایر قالب‌ها، مانند چاپ با حروف درشت، در دسترس شما هستند. برای برنامه‌های پزشکی با شماره 1-866-260-2723 و برای طرح چشم پزشکی با شماره 1-800-638-3120 و برای طرح دندانپزشکی با شماره 1-877-816-3596، یا با (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط تلفن رایگان سازمان

ATTENTION : Vous pouvez demander à un(e) interprète de parler à votre médecin au moment de votre rendez-vous ou avec nous. Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le 1-866-260-2723 pour les régimes médicaux, le 1-800-638-3120 pour les régimes de soins de la vue, le 1-877-816-3596 pour les régimes de soins dentaires, ou appelez le numéro de téléphone gratuit indiqué sur votre carte de membre. (TTY : 711).

ACHTUNG: Sie können für Gespräche mit Ihrem Arzt bei Ihrem Termin oder mit uns einen Dolmetscher anfordern. Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistentendienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie 1-866-260-2723 für Krankenversicherungen, 1-800-638-3120 für Augenversicherungen, 1-877-816-3596 für Zahnversicherungen oder die gebührenfreie Telefonnummer auf Ihrer Mitgliedskarte an. (TTY: 711).

ΠΡΟΣΟΧΗ: Μπορείτε να πάρετε έναν διερμηνέα για να μιλήσετε με το γιατρό σας στο ραντεβού σας ή για να μιλήσετε μαζί μας. Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε στο 1-866-260-2723 για ιατρικά προγράμματα, στο 1-800-638-3120 για οφθαλμολογικά προγράμματα, στο 1-877-816-3596 για οδοντιατρικά προγράμματα ή καλέστε τον αριθμό τηλεφώνου χωρίς χρέωση που αναγράφεται στην κάρτα μέλους σας. (TTY: 711).

ધ્યાન આપો: તમે તમારી મુલાકાત સમયે અથવા અમારી સાથે તમારા ડોક્ટર સાથે વાત કરવા માટે દુભાષિયા મેળવી શકો છો. જો તમે ગુજરાતી (Gujarati), બોલો છો, તો મફત ભાષા સહાયતા સેવાઓ અને અન્ય ફોર્મેટમાં મફત સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. મેડિકલ પ્લાન માટે 1-866-260-2723, વિઝન પ્લાન માટે 1-800-638-3120, ડેન્ટલ પ્લાન માટે 1-877-816-3596 પર કોલ કરો અથવા તમારા સભ્ય આઈડી કાર્ડ પર સુચિબદ્ધ ટોલ-ફ્રી ફોન નંબર પર કોલ કરો. (TTY: 711).

ATANSYON: Ou ka jwenn yon entèprèt pou pale ak doktè ou a nan moman randevou w la oswa avèk nou. Si w pale **Kreyòl Ayisyen (Haitian Creole)**, sèvis asistans lang gratis ak kominikasyon gratis nan lòt fòm, tankou gwo lèt, disponib pou ou. Rele 1-866-260-2723 pou Plan Medikal, 1-800-638-3120 pou Plan Vizyon, 1-877-816-3596 pou Plan Dantè, oswa rele nimewo telefòn gratis ki endike sou kat ID manm ou a. (TTY: 711).

ध्यान दें: आप अपनी अपॉइंटमेंट के समय या हमारे साथ अपने डॉक्टर से बात करने के लिए एक दुभाषिया प्राप्त कर सकते हैं। यदि आप हिन्दी (Hindi) बोलते हैं, तो मुफ्त भाषा सहायता सेवाएँ और बड़े प्रिंट जैसे अन्य प्रारूपों में मुफ्त संचार सेवा आपके लिए उपलब्ध हैं। मेडिकल प्लान के लिए 1-866-260-2723 पर कॉल करें, विजन प्लान के लिए 1-800-638-3120 पर, डेंटल प्लान के लिए 1-877-816-3596 पर कॉल करें, या अपने सदस्य आईडी कार्ड पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें। (TTY: 711)

CEEB TOOM: Koj tuaj yeem tau txais ib tug neeg txhais lus tham nrog koj tus kws kho mob thaum lub sijhawm kev teem caij los sis thaum tham nrog peb. Yog tias koj hais **Lus Hmoob (Hmong)**, yuav muaj cov kev pab cuam txhais lus pub dawb thiab kev sib txuas lus ua lwm hom qauv, xws li luam ua tus ntawv loj rau koj. Hu rau **1-866-260-2723** rau Cov Phiaj Xwm Kho Mob, **1-800-638-3120** rau Cov Phiaj Xwm Kho Qhov Muag, **1-877-816-3596** rau Cov Phiaj Xwm Kho Hniav, los yog hu rau tus xov tooj hu dawb uas teev rau hauv koj daim npav ID. (TTY: 711).

ATENSIÓN: Makaalaka iti interpreter a makisarita kadakami wenno iti doktormo iti oras ti appointment-mo. No makasaoka iti **Ilocano (Ilocano)**, makaalaka iti libre a tulong iti lengguahe ken libre a pannakikomunikar iti sabali a format, kas iti dadakkel a letra. Tawagam ti **1-866-260-2723** para kadagiti Plan a Medikal, **1-800-638-3120** para kadagiti Plan para iti Panagkita, **1-877-816-3596** para kadagiti Plan para iti Ngipen, wenno tawagam ti libre a numero ti telepono a nailista iti ID card-mo kas miembro. (TTY: 711).

ATTENZIONE: il giorno del Suo appuntamento, può richiedere i servizi di un interprete per parlare con il Suo medico o con noi. Se parla **italiano (Italian)**, sono disponibili gratuitamente servizi di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero **1-866-260-2723** per i piani sanitari, il numero **1-800-638-3120** per i piani oculistici e il numero **1-877-816-3596** per i piani dentistici, oppure chiami il numero verde riportato sul Suo tesserino identificativo. (TTY: 711).

ご注意：ご予約にお越しの際またはご来院の際、医師とお話になるための通訳者を手配することが可能です。あなたが**日本語 (Japanese)**をお話になる場合、無料の言語支援サービスおよび大きい活字など他の形式による無料のコミュニケーションをご利用になれます。医療プランについては**1-866-260-2723**、眼科プランについては**1-800-638-3120**、歯科プランについては**1-877-816-3596**までお電話いただくか、メンバー ID カードに記載の通話料無料の番号までお電話ください。(TTY: 711)。

주의: 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다.

한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 큰 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 의료 플랜의 경우 **1-866-260-2723**, 안과 플랜의 경우

1-800-638-3120, 치과 플랜의 경우 **1-877-816-3596**번으로 전화하거나 귀하의 회원 ID 카드에 기재된 무료 전화번호로 전화하십시오. (TTY: 711).

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

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

ध्यान दिनुहोस्: तपाईंले आफ्नो अपोइन्टमेन्टको समयमा वा हामीसँग आफ्नो डाक्टरसँग कुरा गर्ने दोभाषे लिन सक्नुहुन्छ। तपाईं **नेपाली (Nepali)** बोलुनुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र ठूलो अक्षर जस्ता अन्य ढाँचाहरूमा निःशुल्क सञ्चार सेवाहरू तपाईंको लागि उपलब्ध छन्। चिकित्सा योजनाहरूको लागि 1-866-260-2723 भिजन योजनाहरूको लागि 1-800-638-3120 दन्त योजनाहरूको लागि 1-877-816-3596 मा कल गर्नुहोस्, वा तपाईंको सदस्य परिचयपत्रमा सूचीबद्ध टोल-फ्री फोन नम्बरमा कल गर्नुहोस्। (TTY: 711)

WICHDICH: Du darfst en Interpreter griege fer schwetze mit dei Dokter an dei Appointment odder mit uns. Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht un brauchschtf Hilf fer communicat-e, kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Call 1-866-260-2723 fer Plans as zu duh hen mit Dokteres, 1-800-638-3120 fer Plans as zu duh hen mit Sehne, 1-877-816-3596 fer Plans as zu duh hen mit Zaeh, odder call die Toll-Free Phone Number as uff dei ID Card is. (TTY: 711).

UWAGA: Możesz poprosić tłumacza o pomoc w rozmowie z lekarzem w czasie wizyty lub z nami. Osoby mówiące w języku **polskim (Polish)**, mają dostęp do bezpłatnej usługi pomocy językowej i bezpłatnej komunikacji w innych formatach, takich jak duży druk. Zadzwoń pod numer 1-866-260-2723 w celu uzyskania informacji o planach medycznych, 1-800-638-3120 o planach okulistycznych, 1-877-816-3596 o planach stomatologicznych lub zadzwoń pod bezpłatny numer telefonu podany na karcie członkowskiej. (TTY: 711).

ATENÇÃO: Você pode ter um intérprete para falar com o médico no momento da consulta ou conosco. Se você fala **português (Portuguese)**, há serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, disponíveis para você. Ligue para 1-866-260-2723 para planos médicos, 1-800-638-3120 para planos oftalmológicos, 1-877-816-3596 para planos odontológicos ou ligue para o número de telefone gratuito listado no seu cartão de ID de membro. (TTY: 711).

ਧਿਆਨ ਦਿਓ: ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਬਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਮੁਫਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਮੈਡੀਕਲ ਯੋਜਨਾਵਾਂ ਲਈ 1-866-260-2723, ਵਿਜ਼ਨ ਯੋਜਨਾਵਾਂ ਲਈ 1-800-638-3120, ਡੈਂਟਲ ਯੋਜਨਾਵਾਂ ਲਈ 1-877-816-3596 'ਤੇ ਕਾਲ ਕਰੋ, ਜਾਂ ਆਪਣੇ ਮੈਂਬਰ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਟੋਲ-ਫ੍ਰੀ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

ВНИМАНИЕ! Вы можете воспользоваться услугами устного переводчика для общения с вашим врачом во время приема или через наши услуги. Если вы говорите на **русском языке (Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Позвоните по телефону **1-866-260-2723** для медицинских планов, **1-800-638-3120** для планов по охране зрения, **1-877-816-3596** для планов по стоматологическим услугам или на линию для бесплатного звонка, указанную на вашей идентификационной карточке участника. (Линия TTY: 711).

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au **1-866-260-2723** mo Fuafuaga Fa'afoma'i, **1-800-638-3120** mo Fuafuaga Va'ai, **1-877-816-3596** mo Fuafuaga Nifo, pe vala'au le numera telefoni e leai se totogi o lo'o lisiina i luga o lau pepa ID tagata. (TTY: 711).

FIIRO GAAR AH: Waxaad heli kartaa turjumaan si aad ula hadasho dhakhtarkaaga wakhtiga ballanta ama annaga. Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac **1-866-260-2723** wixii ah Qorshayaasha Caafimaadka, **1-800-638-3120** Qorshooyinka Aragtida, **1-877-816-3596** wixii ah Qorshooyinka Ilkaha, ama wac lambarka telefoonka bilaashka ah ee ku qoran kaarka aqoonsiga xubinta. (TTY: 711).

ATENCIÓN: Puede conseguir un intérprete para hablar con nosotros o con su médico durante su cita. Si usted habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia en otros idiomas y comunicaciones gratuitas en otros formatos, como letra grande. Llame al **1-866-260-2723** para los planes médicos, al **1-800-638-3120** para los planes de la vista y al **1-877-816-3596** para los planes dentales, o llame al número de teléfono gratuito que aparece en su tarjeta de identificación de membresía. (TTY: 711).

PAUNAWA: Maaari kang makakuha ng interpreter upang makausap ang iyong doktor sa panahon ng iyong appointment o sa pakikipag-usap sa amin. Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa **1-866-260-2723** para sa Mga Planong Medikal, **1-800-638-3120** para sa Mga Plano para sa Pangingin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tumawag nang libre sa numero ng telepono na nakalista sa iyong ID card ng miyembro. (TTY: 711).

หมายเหตุ: คุณจะสามารถขอคำปรึกษาเกี่ยวกับแพทย์ของคุณได้ไม่ว่าอยู่ที่ใดผ่านนักแปลหรือกับเรา หากคุณพูดภาษาไทย (**Thai**)

เรายินดีให้บริการช่วยเหลือด้านภาษาและการสื่อสารในรูปแบบอื่นๆ เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่โดยไม่คิดค่าใช้จ่าย โทร **1-866-260-2723**

สำหรับการวางแผนทางการแพทย์ **1-800-638-3120** สำหรับการวางแผนด้านอื่นๆ **1-877-816-3596** สำหรับการวางแผนด้านทันตกรรม

หรือโทรไปยังหมายเลขโทรศัพท์ที่เราจะระบุไว้ในบัตรประจำตัวสมาชิกของคุณ (TTY: 711)

ЗВЕРНІТЬ УВАГУ! Під час прийому у лікаря або розмови з нами ви маєте змогу скористатися послугами усного перекладача. Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як-от набрані великим шрифтом. Телефонуйте на номер **1-866-260-2723** щодо планів медичного страхування, на номер **1-800-638-3120**, щоб дізнатися докладніше про плани страхового покриття офтальмологічних послуг, на номер **1-877-816-3596**, щоб дізнатися докладніше про плани страхового покриття стоматологічних послуг, або телефонуйте на номер безкоштовної телефонної лінії, зазначений на вашій ідентифікаційній картці учасника. (лінія TTY: 711).

توجہ فرمائیں: آپ اپنی ملاقات کے وقت یا ہمارے ساتھ اپنے ڈاکٹر سے بات کرنے کے لیے مترجم حاصل کر سکتے ہیں۔ اگر آپ اردو (Urdu) بولتے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیٹس مثلاً بڑے پرنٹ میں مفت مواصلات آپ کے لیے دستیاب ہیں۔ میڈیکل پلانز کے لیے **1-866-260-2723** پر، ویژن پلانز کے لیے **1-800-638-3120**، ڈیٹیل پلانز کے لیے **1-877-816-3596** پر کال کریں، یا (TTY: 711) ۱

LƯU Ý: Quý vị có thể có một thông dịch viên miễn phí để nói chuyện với bác sĩ trong buổi hẹn khám của mình hoặc nói chuyện với chúng tôi. Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Hãy gọi **1-866-260-2723** cho các Chương trình Y tế, **1-800-638-3120** cho các Chương trình Nhãn khoa, **1-877-816-3596** cho các Chương trình Nha khoa, hoặc gọi số điện thoại miễn phí được ghi trên thẻ ID hội viên của quý vị. (TTY: 711).