



OXFORD HEALTH INSURANCE, INC.
HSA EPO PLAN
SUMMARY OF COVERAGE
Liberty Network
Magen David Yeshivah

BENEFIT	COVERAGE
FINANCIAL	
Deductible:	Single \$5,500 Family \$11,000*
Coinsurance	30%
Maximum Out-of-Pocket:	Single \$6,350 Family \$12,700
Financial Accumulation Period:	Calendar Year
<i>Please Note: All Copayments, Deductibles, and Coinsurance (medical and prescription) paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.</i>	
PREVENTIVE CARE	
Adult Preventive Care	No Charge
Infant and Pediatric Preventive Care	No Charge
OUTPATIENT CARE	
Primary Care Physician Office Visits	Deductible & 30% Coinsurance
Specialist Office Visits	Deductible & 30% Coinsurance
Virtual Visits	No Charge
Outpatient Surgery - Hospital Setting	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 30% Coinsurance
Laboratory Services - Hospital Setting	Deductible & 30% Coinsurance
Laboratory Services - Freestanding Facility	Deductible & 30% Coinsurance
<i>(See your Certificate of Coverage for additional Lab details)</i>	
Radiology Services - Hospital Setting	Deductible & 30% Coinsurance
Radiology Services - Freestanding Facility	Deductible & 30% Coinsurance
DIABETIC SUPPLIES AND MEDICATIONS	
Diabetic Supplies	Deductible & 30% Coinsurance
Diabetic Medications	Deductible & 30% Coinsurance
MRIs, MRAs, CT SCANS, AND PET SCANS	
Outpatient Hospital Services	Deductible & 30% Coinsurance
Freestanding Radiology Facility	Deductible & 30% Coinsurance
HOSPITAL CARE	
Physician's and Surgeon's Services	Deductible & 30% Coinsurance
Semi-Private Room and Board	Deductible & 30% Coinsurance
All Drugs and Medication	Deductible & 30% Coinsurance
EMERGENCY CARE	
Ambulance Service when Medically Necessary	Deductible & 30% Coinsurance
At Hospital Emergency Room	Deductible & 30% Coinsurance
<i>(If member is admitted to the hospital, notification is required)</i>	
Emergency Care in Urgi-Center	Deductible & 30% Coinsurance
MATERNITY CARE	
Routine Prenatal and Post-Natal Care	No Charge
Hospital Services for Mother and Child	Deductible & 30% Coinsurance
SKILLED NURSING FACILITY	
30 Days per Calendar Year	Deductible & 30% Coinsurance
HOSPICE CARE	
Inpatient Care	Deductible & 30% Coinsurance
Home Hospice Care Visits	Deductible & 25% Coinsurance
HOME HEALTH CARE	
Home Care Visits - 40 Visits per Calendar Year	Deductible & 25% Coinsurance
Physician House Calls	Deductible & 30% Coinsurance
SUBSTANCE USE DISORDER SERVICES	
Inpatient Rehabilitation	Deductible & 30% Coinsurance
Office Visits or Outpatient Rehabilitation	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization	Deductible & 30% Coinsurance
MENTAL HEALTH CARE	
Inpatient Care	Deductible & 30% Coinsurance
Office Visits or Outpatient Care	Deductible & 30% Coinsurance
Outpatient Partial Hospitalization	Deductible & 30% Coinsurance

BENEFIT	COVERAGE
ALLERGY CARE	
Testing and Treatment	Deductible & 30% Coinsurance
CHIROPRACTIC CARE	
Chiropractic Care	Deductible & 30% Coinsurance
SHORT TERM REHAB OR HABILITATIVE SERVICES	
60 Inpatient Days per Calendar Year	Deductible & 30% Coinsurance
Outpatient limited to 60 combined PT/OT/ST Visits per Calendar Year	Deductible & 30% Coinsurance
DURABLE MEDICAL EQUIPMENT	
Unlimited <i>(Precert required for items over \$500)</i>	Deductible & 30% Coinsurance
HEARING AIDS	
Limited to a single purchase (including repair/replacement) every 3 Years.	Deductible & 30% Coinsurance
MEDICAL SUPPLIES	
Medical Supplies when Medically Necessary	Deductible & 30% Coinsurance
EXERCISE FACILITY	
Subscriber	\$200 reimbursement per 6 month period
Spouse/Dependents over age 13	\$100 reimbursement per 6 month period
INFERTILITY TREATMENT	
(Covers all services in compliance with the NY Infertility Mandate)	
Specialist Office Visits	Deductible & 30% Coinsurance
Inpatient Facility Services	Deductible & 30% Coinsurance
Outpatient Surgery - Hospital Setting	Deductible & 30% Coinsurance
Outpatient Surgery - Freestanding Facility	Deductible & 30% Coinsurance
OUTPATIENT PRESCRIPTION DRUGS - DEDUCTIBLE	Subject to Plan Deductible then applicable Prescription Drug Copay
OUTPATIENT PRESCRIPTION DRUGS - RETAIL	
<i>The Prescription Drug Benefit is based on a per Calendar Year limit for any applicable deductibles and/or maximum limits.</i>	
Tier 1	\$10 copay
Tier 2	\$25 copay
Tier 3	\$50 copay
OUTPATIENT PRESCRIPTION DRUGS - MAIL ORDER	
Tier 1	\$25.00 copay
Tier 2	\$62.50 copay
Tier 3	\$125.00 copay

DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26. Benefits discontinue at the end of the Month.

*If you have a family contract, the entire family Deductible must be satisfied before coverage under this Plan is available. A family contract is a Plan that covers you and one or more dependents.


Please be advised this sample summary of coverage is provided for informational purposes only. The information contained herein is subject to approval of the New York Department of Insurance and Oxford home office approval as appropriate. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.

Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Workers' Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.



 **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.whyuhc.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: \$5,500 Individual / \$11,000 Family Per calendar year.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,350 Individual / \$12,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	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 network provider?	Yes. See www.whyuhc.com or call 1-800-444-6222 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 referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (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	30% <u>coinsurance</u>	Not Covered	Virtual visits (Telehealth) - 0% <u>coinsurance</u> per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	Specialist visit	30% <u>coinsurance</u>	Not Covered	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing Lab: 30% <u>coinsurance</u> Hospital Lab: 30% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing: 30% <u>coinsurance</u> Hospital: 30% <u>coinsurance</u>	Not Covered	None

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.whyuhc.com/welcometouhc/pharmacy-benefits.</p>	Tier 1	Retail: \$15 <u>copay</u> Mail-Order: \$37.50 <u>copay</u>	Not Covered	Provider means pharmacy for purposes of this section.
	Tier 2	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Not Covered	Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply
	Tier 3	Retail: \$75 <u>copay</u> Mail-Order: \$187.50 <u>copay</u>	Not Covered	If you use a out of network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . 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 <u>prescribed drugs</u> .
	Tier 4	Not Applicable	Not Applicable	Tier not applicable for this <u>plan</u> .
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Ctr: 30% <u>coinsurance</u> Hospital: 30% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not Covered	None
<p>If you need immediate medical attention</p>	Emergency room care	30% <u>coinsurance</u>	30% <u>coinsurance*</u>	*Network Deductible applies
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance*</u>	*Network Deductible applies
	Urgent care	30% <u>coinsurance</u>	Not Covered	If you receive services in addition to <u>Urgent Care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.

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 a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not Covered	Network partial hospitalization/intensive outpatient treatment/high intensity outpatient: 30% coinsurance Intensive Behavior Therapy (ABA): 30% coinsurance
	Inpatient services	30% coinsurance	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 services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	30% coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	30% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not Covered	Limited to 40 visits per calendar year. Home intravenous infusion is not covered out-of-Network.
	Rehabilitation services	30% coinsurance	Not Covered	Limits per calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Habilitation services	30% coinsurance	Not Covered	Limits per calendar year: Physical, Speech and Occupational therapy combined limit 60 visits.
	Skilled nursing care	30% coinsurance	Not Covered	Limited to 30 days per calendar year.
	Durable medical equipment	30% coinsurance	Not Covered	Preauthorization required for DME over \$500 or there is no coverage
	Hospice services	30% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for children's glasses
	Children's dental check-up	Not Covered	Not Covered	No coverage for children's dental check-up.

Excluded Services & Other Covered Services:

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

- | | | |
|----------------------|--|----------------------------------|
| • Acupuncture | • Dental Care (Adult/Child) | • Routine Eye Care (Adult/Child) |
| • Children's Glasses | • Long-Term Care | • Routine Foot Care |
| • Cosmetic Surgery | • Non-emergency care when traveling outside - the U.S. | • 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 | • Private-duty nursing |
| | • Hearing aids | • Infertility Treatment |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 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: 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, kwijigo holne' 1-866-633-2446.

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

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,500
- Specialist coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$5,500
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,360

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

- The plan's overall deductible \$5,500
- Specialist coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,700

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

- The plan's overall deductible \$5,500
- Specialist coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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

Notice of Non-Discrimination

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), TTY711, 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 <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>.

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

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), TTY711, 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 연락하십시오

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 بدخل مخلص المزايا والتغطية (Summary of Benefits and Coverage) 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 हैं, आपको भाषा सहायता सेवाएं, 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: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកក់ចេញថ្លៃ ដែលមានកក់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of

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 yánilti'go, saad bee áka'anida'awo'ígíí, t'áá jíílk'eh, bee ná'ahóót'i. T'áá shqodí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíílk'ehgo béésh bee hane'í biká'ígíí bee hodfilnih.

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).