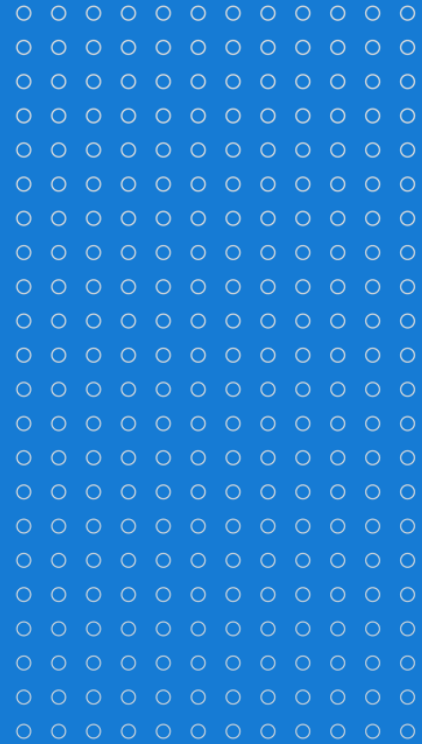


Employee Benefits Notices and Forms Templates

Annual, New Hire, and Other Notices and Forms

Please note: While HUB is providing these notices as a courtesy to its clients, HUB does not provide legal or tax advice. HUB makes no representation or warranty as to the accuracy or completeness of these documents and is not obligated to update them. Consult your attorney and/or professional advisor as to your organization's specific circumstances and legal, tax or other requirements.



Medicare Part D Creditable Coverage Notice

Important Notice from BA Holdings, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BA Holdings, Inc. (the “Plan Sponsor”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

- (1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- (2) The Plan Sponsor has determined that the prescription drug coverage offered by the BA Holdings, Inc., Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan Sponsor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

| | |
|--------------------------|--|
| Date: | 11/11/2024 |
| Name of Entity/Sender: | BA Holdings, Inc. |
| Contact-Position/Office: | Employee Benefits & Compensation Manager |
| Address: | 2940 Highland Ave., Unit #210, Cincinnati, OH 45212 |
| Phone Number: | 513-685-9224 |

CHIPRA/CHIP Notice

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility -

| | |
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| ALABAMA – Medicaid | CALIFORNIA – Medicaid |
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov |
| ALASKA – Medicaid | COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx | Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442 |
| ARKANSAS – Medicaid | FLORIDA – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268 |

| | |
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| <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p> | <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p> |
| INDIANA – Medicaid | MINNESOTA – Medicaid |
| <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p> | <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p> |
| IOWA – Medicaid and CHIP (Hawki) | MISSOURI – Medicaid |
| <p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p> | <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p> |
| KANSAS – Medicaid | MONTANA – Medicaid |
| <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p> | <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p> |
| KENTUCKY – Medicaid | NEBRASKA – Medicaid |
| <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p> | <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p> |
| LOUISIANA – Medicaid | NEVADA – Medicaid |
| <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p> | <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p> |

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| <p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p> | <p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p> |
| <p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p> | <p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p> |
| <p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p> | <p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p> |
| <p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p> | <p align="center">UTAH – Medicaid and CHIP</p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p> |
| <p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p> | <p align="center">VERMONT– Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427</p> |
| <p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p> | <p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p> |
| <p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p> | <p align="center">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p> |
| <p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p> | <p align="center">WEST VIRGINIA – Medicaid and CHIP</p> <p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p> |
| <p align="center">RHODE ISLAND – Medicaid and CHIP</p> | <p align="center">WISCONSIN – Medicaid and CHIP</p> |

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| Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line) | Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 |
| SOUTH CAROLINA – Medicaid | WYOMING – Medicaid |
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

Employee Benefits Security Administration

U.S. Department of Labor
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

Centers for Medicare & Medicaid Services

U.S. Department of Health and Human Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **513-685-9224** for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

BA Holdings, Inc.
2940 Highland Ave., Unit #210, Cincinnati, OH 45212
11/11/2024

To: Participants in the medical, dental, vision, HSA, FSA, life and disability, accident, critical illness, and hospital indemnity.

From: Lorie Kravetsky, Employee Benefits & Compensation Manager

Re: Availability of Notice of Privacy Practices

The medical, dental, vision, HSA, FSA, life and disability, accident, critical illness, and hospital indemnity (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Lorie Kravetsky, Employee Benefits & Compensation Manager at 2940 Highland Ave., Unit #210, Cincinnati, OH 45212, 513-685-9224, Lorie.Kravetsky@Luxfer.com.

Notice of Marketplace Coverage Options

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through November 30, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and November 30, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and November 30, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **Lorie Kravetsky, Employee Benefits & Compensation Manager** at **2940 Highland Ave., Unit #210, Cincinnati, OH 45212, 513-685-9224, Lorie.Kravetsky@Luxfer.com.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | |
|---|---|
| 3. Employer name BA Holdings, Inc. | 4. Employer Identification Number (EIN) 33-0712701 |
| 5. Employer address, 7. City, 8. State, 9. Zip Code 2940 Highland Ave., Unit #210, Cincinnati, OH 45212 | 6. Employer phone number 513-685-9224 |
| 10. Who can we contact about employee health coverage at this job? Lorie Kravetsky, Employee Benefits & Compensation Manager | |
| 11. Phone number (if different from above) 513-685-9224 | 12. Email address Lorie.Kravetsky@Luxfer.com |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Full- time working 30 or more hours per week

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Legally married spouses, domestic partners and legal children (by birth, adoption, or marriage) to age 26.

We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 30 days after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact BA Holdings, Inc., Human Resource Dept. at 513-685-9224.



Select CULC

Coverage For: Family | Plan Type: EPO



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, call 1-866-633-2446 or visit welcometouhc.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 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | <u>Network: \$1,000 Individual / \$2,000 Family</u> 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 <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 Services</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the annual <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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | <u>Network: \$5,000 Individual / \$10,000 Family</u> Per calendar year. | 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> ? | <u>Premiums</u> , <u>balance-billing</u> charges, 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.myuhc.com or call 1-866-633-2446 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 |
|---|--|--|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | Virtual Visits - No Charge by a Designated Virtual <u>Network Provider</u> . *Cost Share applies to any other Telehealth service based on <u>provider</u> type. 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. |
| | <u>Specialist visit</u> | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply | 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. |
| | <u>Preventive care/ screening/ immunization</u> | 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 | <u>Diagnostic test</u> (x-ray, blood work) | Lab Testing: Free Standing/Office: No Charge Hospital: 20% <u>coinsurance</u> , <u>deductible</u> does not apply X-Ray/Diagnostics: 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | Not Covered | None |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at welcometouhc.com | Tier 1 - Your Lowest Cost Option | Retail: \$15 <u>copay, deductible</u> does not apply. Mail-Order: \$30 <u>copay, deductible</u> does not apply. Specialty Retail: \$15 <u>copay, deductible</u> does not apply. | Not Covered | <p><u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail <u>Network Pharmacy</u>. Specialty drugs are not covered through mail order.</p> <p>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. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>.</p> <p>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.</p> <p>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 prescribed drugs.</p> |
| | Tier 2 - Your Mid-Range Cost Option | Retail: \$30 <u>copay, deductible</u> does not apply. Mail-Order: \$60 <u>copay, deductible</u> does not apply. Specialty Retail: \$30 <u>copay, deductible</u> does not apply. | Not Covered | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | Not Covered | |
| | Tier 4 - Your Highest Cost Option | Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | Not Applicable | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | Not Covered | None |
| | Physician/ surgeon fees | 20% <u>coinsurance</u> | Not Covered | None |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Urgent Care</u> | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not Covered | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | <u>Network Partial hospitalization/intensive outpatient treatment</u> : 20% <u>coinsurance</u> See your policy or <u>plan</u> document for additional information about EAP benefits. |
| | Inpatient services | 20% <u>coinsurance</u> | Not Covered | See your policy or <u>plan</u> document for additional information about EAP benefits. |
| If you are pregnant | Office Visits | No Charge | Not Covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not Covered | Depending on the type of service 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 facility services | 20% <u>coinsurance</u> | Not Covered | None |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not Covered | Limited to 100 visits per calendar year. |
| | <u>Rehabilitation services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | Outpatient <u>rehabilitation services</u> are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. |
| | <u>Habilitative services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | Not Covered | Skilled Nursing is limited to 100 days per calendar year. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not Covered | None |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not Covered | Limited to 1 exam every 24 months. |
| | 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 | • Infertility Treatment | • Private duty nursing |
| • Cosmetic Surgery | • Long Term Care | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | • Non-emergency care when traveling outside - the US | |
| • Glasses | | |

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 - 24 visits per calendar year | • Routine eye care (Adult) - 1 exam per 24 months |
| | • Hearing aids - \$2,500 per calendar year | • Weight loss programs- Real Appeal |

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: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.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 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.

Traditional 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.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 | \$1,000 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Specialist office visits (pre-natal 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: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,870 |

Managing Joe's type 2 Diabetes

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

| | |
|--|---------|
| ■ The plan's overall deductible | \$1,000 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$700 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The plan's overall deductible | \$1,000 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$1,000 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,400 |

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

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

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

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

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

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

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

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

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

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

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 सेबाएं, निःशुल्क 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។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 yániti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'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 jíik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 **1-800-842-2656**

說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 **1-800-927-4357(Chinese)**

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 ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फ़ोन नंबर पर काल 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer-Cambodian)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

Ուժեղ Դժգոհություն էր ե **հայերեն (Armenian)** եր խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੈਲ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

โปรดทราบ: หากคุณพูดภาษาไทย (Thai) มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่
คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวของคุณ



Select Plus CUJD

Coverage For: Family | Plan Type: PPO



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, call 1-866-633-2446 or visit welcometouhc.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 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | <u>Network</u> : \$1,500 Individual / \$3,000 Family <u>Out-of-Network</u> : \$4,500 Individual / \$9,000 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 <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 deductible? | Yes. <u>Preventive Care Services</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the annual <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? | <u>Network</u> : \$4,500 Individual / \$9,000 Family <u>Out-of-Network</u> : \$13,500 Individual / \$27,000 Family Per calendar year. | 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? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services. | 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.myuhc.com or call 1-866-633-2446 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 | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Virtual Visits - No Charge by a Designated Virtual <u>Network Provider</u> . *Cost Share applies to any other Telehealth service based on <u>provider type</u> . No virtual coverage <u>out-of-network</u> . 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. |
| | <u>Specialist visit</u> | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | 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. |
| | <u>Preventive care/ screening/ immunization</u> | 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. No coverage <u>out-of-network</u> . |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Lab Testing: Free Standing/Office: No Charge Hospital: 20% <u>coinsurance</u> , <u>deductible</u> does not apply X-Ray/Diagnostics: 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Lab Testing: Not Covered X-Ray/Diagnostics: 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . No coverage <u>out-of-network</u> for lab testing. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com | Tier 1 - Your Lowest Cost Option | Retail: \$15 <u>copay, deductible</u> does not apply. Mail-Order: \$30 <u>copay, deductible</u> does not apply. Specialty Retail: \$15 <u>copay, deductible</u> does not apply. | Retail: \$15 <u>copay, deductible</u> does not apply. Specialty Retail: \$15 <u>copay, deductible</u> does not apply. | <p><u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail <u>Network Pharmacy</u>. Specialty drugs are not covered through mail order.</p> <p>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. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>.</p> <p>Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge.</p> <p>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 prescribed drugs.</p> |
| | Tier 2 - Your Mid-Range Cost Option | Retail: \$30 <u>copay, deductible</u> does not apply. Mail-Order: \$60 <u>copay, deductible</u> does not apply. Specialty Retail: \$30 <u>copay, deductible</u> does not apply. | Retail: \$30 <u>copay, deductible</u> does not apply. Specialty Retail: \$30 <u>copay, deductible</u> does not apply. | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | Retail: \$50 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | |
| | Tier 4 - Your Highest Cost Option | Retail: \$50 <u>copay, deductible</u> does not apply. Mail-Order: \$100 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | Retail: \$50 <u>copay, deductible</u> does not apply. Specialty Retail: \$50 <u>copay, deductible</u> does not apply. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <p><u>Out-of-network allowed amounts</u> for Facility Fees are limited to \$760 per date of service.</p> <p><u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u>.</p> |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |

* For more information about limitations and exceptions, see the [plan](#) or policy document at welcometouhc.com.

| 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 need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies. |
| | <u>Urgent Care</u> | \$50 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | <u>Network Partial hospitalization/intensive outpatient treatment</u> : 20% <u>coinsurance</u> See your policy or <u>plan</u> document for additional information about EAP benefits. |
| | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits. |
| If you are pregnant | Office Visits | No Charge | 50% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Depending on the type of service 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 facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Inpatient <u>Preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> . |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 100 visits per calendar year. <u>Out-of-network allowed amounts</u> for Home health care are limited to \$150 per visit. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Rehabilitation services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Outpatient <u>rehabilitation services</u> are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy. |
| | <u>Habilitative services</u> | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Skilled Nursing is limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not covered | No coverage <u>out-of-network</u> . |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> . |
| If your child needs dental or eye care | Children's eye exam | \$25 <u>copay</u> per visit, <u>deductible</u> does not apply | Not covered | Limited to 1 exam every 24 months. No coverage <u>out-of-network</u> . |
| | 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 | • Infertility Treatment | • Private duty nursing |
| • Cosmetic Surgery | • Long Term Care | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | • Non-emergency care when traveling outside - the US | |
| • Glasses | | |

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 - 24 visits per calendar year | • Routine eye care (Adult) - 1 exam per 24 months |
| | • Hearing aids - \$2,500 per calendar year | • Weight loss programs- Real Appeal |

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: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.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 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.

Traditional 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.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-633-2446.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 | \$1,500 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Specialist office visits (pre-natal 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: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,700 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,270 |

Managing Joe's type 2 Diabetes

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

| | |
|--|---------|
| ■ The plan's overall deductible | \$1,500 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$200 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$700 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The plan's overall deductible | \$1,500 |
| ■ Specialist copay | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$1,500 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,800 |

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

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

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

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

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

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

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

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

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

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

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 सेबाएं, निःशुल्क 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។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 yániti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'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 jíik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 **1-800-842-2656**

說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 **1-800-927-4357(Chinese)**

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 ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फ़ोन नंबर पर काल 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer-Cambodian)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

Ուժեղ գործընթացներ էրեն **հայերեն (Armenian)** եր խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੈਲ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

โปรดทราบ: หากคุณพูดภาษาไทย (Thai) มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่
คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวของคุณ



Select Plus HSA Plan EBLH

Coverage For: Family | Plan Type: PPO



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, call 1-866-314-0335 or visit welcometouhc.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 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | <u>Network</u> : \$3,300 Individual / \$6,600 Family <u>Out-of-Network</u> : \$6,000 Individual / \$12,000 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 <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 deductible? | Yes. <u>Preventive Care Services</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 annual <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? | <u>Network</u> : \$5,000 Individual / \$10,000 Family <u>Out-of-Network</u> : \$10,000 Individual / \$20,000 Family Per calendar year. | 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? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services. | 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.myuhc.com or call 1-866-314-0335 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 | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Virtual Visits - 0% <u>coinsurance</u> by a Designated Virtual Network Provider. *Cost Share applies to any other Telehealth service based on <u>provider</u> type. No virtual coverage <u>out-of-network</u> . |
| | <u>Specialist visit</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | <u>Preventive care/ screening/ immunization</u> | 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. No coverage <u>out-of-network</u> . |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Lab Testing: Free Standing/Office: 20% <u>coinsurance</u> Hospital: 50% <u>coinsurance</u> X-Ray/Diagnostics: 20% <u>coinsurance</u> | Lab Testing: Not Covered X-Ray/Diagnostics: 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u> . No coverage <u>out-of-network</u> for lab testing. |
| | Imaging (CT/PET scans, MRIs) | Free Standing/Office: 20% <u>coinsurance</u> Hospital: 50% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com | Tier 1 - Your Lowest Cost Option | Retail: \$15 <u>copay</u> Mail-Order: \$30 <u>copay</u> Specialty Retail: \$15 <u>copay</u> | Retail: \$15 <u>copay</u> Specialty Retail: \$15 <u>copay</u> | <p><u>Provider</u> means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail <u>Network Pharmacy</u>. Specialty drugs are not covered through mail order. 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. If you use an <u>out-of-network</u> pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u>. 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 prescribed drugs. Prescription drug costs are subject to the annual <u>deductible</u>. <u>Network deductible</u> will be applied to the <u>out-of-network provider</u> and applies to the <u>Network out-of-pocket limit</u>.</p> |
| | Tier 2 - Your Mid-Range Cost Option | Retail: \$30 <u>copay</u> Mail-Order: \$60 <u>copay</u> Specialty Retail: \$30 <u>copay</u> | Retail: \$30 <u>copay</u> Specialty Retail: \$30 <u>copay</u> | |
| | Tier 3 - Your Mid-Range Cost Option | Retail: \$50 <u>copay</u> Mail-Order: \$100 <u>copay</u> Specialty Retail: \$50 <u>copay</u> | Retail: \$50 <u>copay</u> Specialty Retail: \$50 <u>copay</u> | |
| | Tier 4 - Your Highest Cost Option | Retail: \$50 <u>copay</u> Mail-Order: \$100 <u>copay</u> Specialty Retail: \$50 <u>copay</u> | Retail: \$50 <u>copay</u> Specialty Retail: \$50 <u>copay</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <p><u>Out-of-network allowed amounts</u> for Facility Fees are limited to \$760 per date of service. <u>Preauthorization</u> is required <u>out-of-network</u> for certain services or benefit reduces to 50% of <u>allowed amount</u>.</p> |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at welcometouhc.com.

| 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 need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | *20% <u>coinsurance</u> | * <u>Network deductible</u> applies. |
| | <u>Urgent Care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Network Partial hospitalization/intensive outpatient treatment</u> : 20% <u>coinsurance</u> See your policy or <u>plan</u> document for additional information about EAP benefits. |
| | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . See your policy or <u>plan</u> document for additional information about EAP benefits. |
| If you are pregnant | Office Visits | No Charge | 50% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Depending on the type of service 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 facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Inpatient <u>Preauthorization</u> applies <u>out-of-network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of <u>allowed amount</u> . |

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

| 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 need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 100 visits per calendar year. <u>Out-of-network allowed amounts</u> for Home health care are limited to \$150 per visit. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Outpatient <u>rehabilitation services</u> are unlimited per calendar year. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy. |
| | <u>Habilitative services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Services are provided under <u>Rehabilitation Services</u> above. No limits apply for treatment of Autism Spectrum Disorder Services. No coverage <u>out-of-network</u> for physical and occupational therapy. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Skilled Nursing is limited to 100 days per calendar year. <u>Preauthorization</u> is required <u>out-of-network</u> or benefit reduces to 50% of <u>allowed amount</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not covered | No coverage <u>out-of-network</u> . |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> is required <u>out-of-network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of <u>allowed amount</u> . |
| If your child needs dental or eye care | Children's eye exam | 20% <u>coinsurance</u> | Not covered | Limited to 1 exam every 24 months. No coverage <u>out-of-network</u> . |
| | 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 | • Infertility Treatment | • Private duty nursing |
| • Cosmetic Surgery | • Long Term Care | • Routine foot care - Except as covered for Diabetes |
| • Dental Care | • Non-emergency care when traveling outside - the US | |
| • Glasses | | |

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 - 24 visits per calendar year | • Routine eye care (Adult) - 1 exam per 24 months |
| | • Hearing aids - \$2,500 per calendar year | • Weight loss programs- Real Appeal |

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: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.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 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 1-866-314-0335.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-0335.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-314-0335.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-314-0335.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-314-0335 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-314-0335.

Carolinian (Kapasal Falawasch): ngere aukke ghut allis reel kapasal Falawasch au fafaingi tilifon ye 1-866-314-0335.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-314-0335.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)

| | |
|--|---------|
| ■ <u>The plan's overall deductible</u> | \$3,300 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

This EXAMPLE event includes services like:

Specialist office visits (pre-natal 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: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$3,300 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,970 |

Managing Joe's type 2 Diabetes

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

| | |
|--|---------|
| ■ <u>The plan's overall deductible</u> | \$3,300 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other 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 |
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$1,700 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$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)

| | |
|--|---------|
| ■ <u>The plan's overall deductible</u> | \$3,300 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other 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 |
| In this example, Mia would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$2,800 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$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.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: [UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

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

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

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

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

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

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

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

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

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

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 सेबाएं, निःशुल्क 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។ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាប់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'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 jíik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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



English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.

Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險公司，電話號碼 **1-800-842-2656**

說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 **1-800-927-4357(Chinese)**

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 ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية **(Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री फ़ोन नंबर पर काल 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer-Cambodian)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

Ուժեղ Դժգոհություն էր ե **հայերեն (Armenian)** եր խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੈਲ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

โปรดทราบ: หากคุณพูดภาษาไทย (Thai) มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่
คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวของคุณ