Alto Operations

Employee Benefits Guide

Plan Year 2026

Carrier Contact Information

Plan	Policy Number	Contact Information
Medical Nexus HSA EPO EI-48 (New) Medical Nexus PPO EI-4H (New) Medical Nexus PPO EI-4O (New) Medical Nexus PPO EI-4N (New)	1567783	UnitedHealthcare 1.866.801.4409 www.myuhc.com
AllyHealth Premium Plan	-	AllyHealth 1.888.565.3303 www.allyhealth.net
Health Savings Account (HSA)	-	Optum Bank 1.866.234.8913 www.optumbank.com
Voluntary Dental	4878	Renaissance 1.800.894.4532 www.renaissancebenefits.com
Voluntary Vision	4878	Renaissance (VSP Choice Network) 1.800.877.7195 www.renaissancebenefits.com

For questions regarding your benefits contact Swingle Collins & Associates at 972.387.3000 or email benefits@swinglecollins.com.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. This is not a plan document. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Guide and the actual plan documents, the carrier plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your guide, contact your Human Resources Department.

Benefit Basics

Alto Operations 2026 Open Enrollment

For the first 12 months of employment, Alto Operations employees will have the option of electing medical coverage through AllyHealth, as well as dental and vision coverage through Renaissance. After 12 months of employment, if you are determined to be eligible by the company, Alto Operations employees will have the option to continue coverage/elect coverage through AllyHealth or can choose one of the 4 medical options offered through UnitedHealthcare. They will also have the option to continue/elect dental and vision coverage through Renaissance.

For the 2026 plan year, Alto will offer 4 medical plans through UnitedHealthcare. Please note all 4 plan offerings are new this year, so please pay special attention to the plans and rates. The medical plans offer quality care, comprehensive coverage, and the ability to utilize the Nexus Open Access and Open Access Plus Networks. In addition to medical, Alto offers all benefits eligible employees the option to enroll in dental and vision coverage. The dental and vision coverages are administered though Renaissance. Lastly, those members enrolling in the HSA medical plan (EI-48) will have the ability to contribute to a Health Savings Account (HSA) administered by Optum Bank. All enrollments should be submitted through the Paycor system. Please review this guide in its entirety for more information on your benefit options.

Who is Eligible?

Full-Time Employees working a minimum of 30 hours per week and their dependents are eligible to enroll in benefits. For new enrollees, coverage begins on the first day of the month following 30 days of employment.

Eligible Dependents may include:

- A legal spouse or common-law spouse, where applicable by state law.
- A domestic partner and domestic partner's children. Please contact HR or refer to the plan documents to determine whether you meet the definition of a domestic partnership.
- Children under age 26. This includes natural children, children that you have legally adopted or have been placed with you while you are in the process of legal adoption, stepchildren, foster children, or children for whom you have obtained legal guardianship or conservatorship.

How Do I Make Changes to my Coverage?

Changes to your level of coverage and/or your benefit program during the year are permitted only when you have a Family Status Change— for example, a marriage, birth, or divorce—as defined by the IRS. If you experience one of the following Qualifying Status Changes during the plan year, you may be able to make changes to your current elections or enroll yourself and/or your eligible dependents:

- You have a change in the size of your family (resulting from marriage, divorce, legal separation, annulment, birth, adoption, placement for adoption or death of a covered family member).
- A court issues a judgment, decree, or order (including a QMCSO) resulting from divorce, legal separation, annulment, or change in legal custody that requires health coverage for your dependent child.
- A dependent no longer satisfies the definition of eligible dependent due to age (such as reaching age 26).
- You or your spouse experiences a substantial change in employment (such as changing between full and part-time employment, a strike or lockout, commencement of or return from unpaid leave of absence).
- Your spouse gains employment or loses a job.
- You, your spouse, or your dependent experiences a significant change in residence or work site.
- You or your dependents lose, or gain healthcare coverage through your spouse's employer or through any group health coverage sponsored by a governmental or educational institution.
- You or your eligible dependent becomes eligible for Medicare or Medicaid (other than solely for pediatric vaccines) or you lose your eligibility for either of these programs.
- Your spouse's employer offers benefits with a different Open Enrollment period.

Changes must be made within 30 days after the qualifying event (60 days if you lose eligibility for Medicaid); after 31 days, a change will not be permitted until the next open enrollment period unless you experience a second qualifying event. The effective date of the change will be the date following the Qualifying Status Change. The type of benefit change allowed depends on, and must be consistent with, the type of event.

Locating an In-Network Provider

You can choose any doctor you wish to see – regardless of whether they are in-network. However, the plan will pay a higher percentage to an in-network provider in most cases. In addition, in-network providers have agreed to accept a contracted rate and they cannot bill you for any additional costs outside this allowable amount.

UHC Medical – Go to www.myuhc.com. Select "Find a Provider" in the middle, left side of the page. Select "Medical Directory" and then "Employer and Individual Plans." Under "What plan are you looking for" select **"NexusACO plans"** the select **"Nexus OA"** for the Nexus HSA EPO EI-48 or **"Nexus ACO OAP"** for the PPO plans **(EI-4H, EI-4O, and EI-4N)**. Choose "Providers In-Network on 1/1/2026, confirm or change you location at the top of the page and then begin searching for in-network providers.

Nexus Tier 1 Providers are indicated with a Tier 1 Provider Stamp. 

Dental – Go to www.renaissancebenefits.com/findaprovider. Scroll to the middle of the page and select "Search Dentists" under "Find a Dentist." Select "Employer Sponsor Plan" under plan type. Enter your location and then select "Search" to begin searching.

Vision – Go to www.renaissancebenefits.com/findaprovider. Scroll to the middle of the page and select "Search Eye Doctors." This will redirect you to the VSP website. Choose to "Search by Location, Search by Office, Search by Doctor, or Shop Online" to begin searching for in-network providers.

Terms to Know

Calendar Year Deductible (CYD): A specified dollar amount you must pay for each covered service before the plan begins to provide payment for benefits. You may be required to pay any applicable deductible at the time you received care from a provider.

Coinsurance: The specific percentage of the provider's reasonable charge for covered services that are your responsibility after meeting the calendar year deductible. You may be required to pay any applicable coinsurance at the time you receive care from a provider.

Family Deductible: For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count expenses incurred by three or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the plan will begin to pay for that person's covered services, even if the deductible for the entire family has not been met.

Family Total Out-of-Pocket: The maximum dollar amount of coinsurance, copays, and deductible incurred by you or your covered family members for covered services received in a benefit period. Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the provider's reasonable charge.

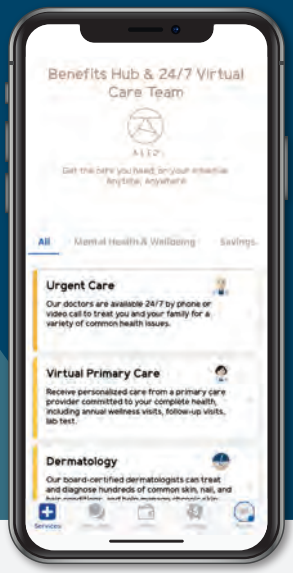
Individual Total Out-of-Pocket: The maximum dollar amount of coinsurance, copays, and deductible you will pay for covered services incurred in a benefit period. When the specified dollar amount is attained, your plan begins to pay 100% of all covered expenses.

Please remember your plan deductibles and out-of-pocket maximums reset on January 1st each year.

AllyHealth

During your first 12 months of employment, you are eligible to enroll in the AllyHealth plan, dental and/or vision.

Cost - $5 Per week



Download the AllyHealth App!

Virtual Care. Anytime. Anywhere.

With AllyHealth, you have 24/7/365 access to virtual urgent care doctor appointments as well as scheduled virtual appointments with primary care doctors and dermatologists. Plus mental health and wellbeing resources including short-term counseling, scheduled therapy, and psychiatry visits.

This is a virtual care benefit only. It is NOT major medical insurance.*

FAST AND CONVENIENT ACCESS TO QUALITY CARE
24 HOURS A DAY 7 DAYS A WEEK 365 DAYS A YEAR

FEATURES AND BENEFITS OF ALLYHEALTH

- Select a Primary Care Physician to manage routine and ongoing health conditions, medication adherence, and preventative care
- Schedule annual wellness visits, order lab and wellness tests, get in-network specialist referrals, and other ongoing, personalized care from a provider committed to your complete health
- Virtual urgent care visits available 24/7/365, on-demand. Anytime. Anywhere
- Specialty visits with dermatologists for any skin issues
- In-the-moment mental health support available 24/7/365, on-demand
- Ongoing, scheduled and structured mental health visits available in an average of less than one week
- Many other mental health and wellbeing resources available to meet you and your family where you are
- Personal concierge to assist with many of life's most common burdens
- Get and stay healthy with our virtual health & wellness coaching
- Prescriptions called in to your local pharmacy
- No copays, deductibles, or per-call charges
- Plan covers your entire family
- Avoid long waits and exposure to germs and viruses
- Rx savings program offers up to 85% discounts at retail pharmacies
- Medical bill negotiation service can help you save on all your medical bills

COMPREHENSIVE TELEHEALTH BENEFITS WORTH USING

With AllyHealth's comprehensive, curated, unique suite of virtual care solutions and support, you and your family have a full care team available in your pockets. And our platform offers flexible access points with mobile apps, online portal, and telephonic access, meeting you and your family where you are and making access simple and easy, 24/7/365. Welcome to the future of healthcare.

ALLYHEALTH
VIRTUAL CARE SOLUTIONS INCLUDE

Virtual Primary Care: $0 Copay*
Allows you and your family to receive personalized care from a primary care provider committed to your complete health, including annual wellness visits, lab/wellness tests, in-network specialist referrals, preventative care, and more.

Virtual Urgent Care: $0 Copay*
Provides you and your family on-demand access to licensed physicians for common illnesses and medications when appropriate, 24/7/365.

Virtual Dermatology: $0 Copay*
Our board-certified dermatologist can treat and diagnose hundreds of common skin, nail, and hair conditions, as well as help manage chronic skin conditions.

On-Demand and Short-Term Counseling: $0 Copay*
24/7/365 access to counselors for in-the-moment mental health counseling, as well as access to scheduled short-term, solution-focused counseling. 100% private and confidential, with free visits included in your plan!*

Scheduled Therapy, Psychology, and Psychiatry Visits: $0 Copay*
Access to scheduled therapy sessions with psychologists for ongoing, proactive mental health therapy as well as psychiatry and medication management. 100% private and confidential, with free visits included in your plan!*

Wellbeing and Practical Daily Support: $0 Copay
Access to a concierge to help with everyday needs (ex: finding eldercare or childcare resources, planning a vacation, financial or legal guidance, and more).

Health & Wellness Coaching: $0 Copay
Want to lose weight? Quit smoking? Eat healthier? Get fit? Improve your overall lifestyle? Our virtual coaches can help you with these goals and more.

Savings Tools: FREE
Save big on your prescriptions and medical bills with our in-app healthcare savings tools.

24/7/365 On-Demand Care. Anytime. Anywhere

www.AllyHealth.net

*THIS PLAN IS NOT INSURANCE. It is a virtual care benefit only. Consultations with our providers are $0 (subject to usage limitations). Up to 10 clinical hours of schedule mental health visits (talk therapy and psychiatry combined) per family per year are included at no charge for employer-paid plans (for voluntary plans, 3 clinical hours are included). Short-term, solution-focused counseling sessions are available with up to 3 free sessions per issue per family member per year (with no limit on issues treated). 5 visits for Health & Wellness coaching. Additional visits may be available on a fee for service basis. If you have any questions about your plan or visit costs, please see your plan administrator, or contact AllyHealth support at support@allyhealth.net.

What is AllyHealth: What is AllyHealth? - AllyHealth

- Welcome to AllyHealth: https://www.allyhealth.net/wp-content/uploads/2023/09/Welcome-to-AllyHealth-2.mp4

- How To Register Your AllyHealth Account: https://www.allyhealth.net/wp-content/uploads/2023/09/How-To-Register-Your-AllyHealth-Account.mp4

- How To Add Dependents: Adding Dependents to Your AllyHealth Account

- Adding Health Records to Your Profile: https://www.allyhealth.net/wp-content/uploads/2023/09/Adding-Health-Records-to-Your-Profile-👩_🈯.mp4

- Setting an Appointment with an AllyHealth Provider: https://www.allyhealth.net/wp-content/uploads/2023/09/Setting-an-Appointment-with-an-AllyHealth-Provider.mp4

Medical Benefits – UnitedHealthcare

After 1 Year of employment, employees who have qualified as full-time employees based on the hours worked in the previous 12 months, have the option to remain enrolled in the before mentioned AllyHealth plans or can select from one of the 4 options below.

MEDICAL	NEXUS HSA EPO EI-48 [1,2,3]		NEXUS PPO EI-4H [2]	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual/ Family)	$5,000/$10,000	Not Covered	$6,000/$12,000	$10,000/$20,000
Co-Insurance (You Pay)	0% (Nexus) / 20% (In-Network)	Not Covered	20% (Nexus) / 40% (In-Network)	50%
Out-of-Pocket (Individual/ Family)	$6,500/$13,000	Not Covered	$8,150/$16,300	$20,000/$40,000
Office Visit (PCP)	Deductible + 0% (Nexus) / Deductible + 20% (In-Network)	Not Covered	$15 Co-Pay (Nexus) / Child < 19: $0 (Nexus) / $45 Co-Pay (In-Network)	Deductible + 50%
Office Visits (Specialist)	Deductible + 0% (Nexus) / Deductible + 20% (In-Network)	Not Covered	$50 Co-Pay (Nexus) / $125 Co-Pay (In-Network)	Deductible + 50%
Preventive Care*	$0	Not Covered	$0	Deductible + 50%
Virtual Visits	Up to $50	Not Covered	$0 Designated Virtual Network Provider	Not Covered
Urgent Care	Deductible + 0%	Not Covered	$50 Co-Pay	Deductible + 50%
Emergency Room	Deductible + 0%		$300 Co-Pay/Visit + Deductible + 20%	

*1 – **No Coverage for Out-of-Network Providers**, 2 – Lower costs will apply if visiting a designated Nexus Tier 1 Provider, 3 – Some states do not allow EPO style plans*
** Age Specifications and Frequency Limitations apply / Refer to your summary plan description for details on how specific services are covered.*

Information about Nexus HSA EPO EI-48 – Please note there are no out-of-network benefits covered under the EPO plan options. You must select in-network providers, facilities, and pharmacies for services to be covered by the plan. In addition, some states do not allow EPOs. Those states include AL, AR, AZ, HI, MS, MT, NC, ND, NM, and OK. If you reside in one of these states and select the EPO you will be automatically moved to the most similar plan option.

All Nexus Plans - Please note additional facility fees may apply prior to your deductible being met should you choose to utilize a facility that is not affiliated with Baylor Scott & White. Lower costs will apply when visiting a designated Tier 1 provider.

Prescriptions (In-Network)	NEXUS HSA EPO EI-48 [1,2,3]	NEUXS PPO EI-4H[2]
Tier 1 (30-Day Supply)	Deductible + $10 Co-Pay	$10 Co-Pay
Tier 2 (30-Day Supply)	Deductible + $35 Co-Pay	$45 Co-Pay
Tier 3 (30-Day Supply)	Deductible + $60 Co-Pay	$80 Co-Pay
Specialty Medications	Same as other Medications	$10 Co-Pay / $150 Co-Pay / $500 Co-Pay
Mail Order	2.5 X Co-Pay for up to a 90-Day Supply UHC's Mail Order Pharmacy is OptumRX	

Monthly Medical Premiums	NEXUS HSA EPO EI-48 [1,2,3]	NEUXS PPO EI-4H[2]
Employee Only	$ 266.01	$ 325.43
Employee + Spouse	$ 965.61	$ 1,032.54
Employee + Child(ren)	$ 782.40	$ 955.53
Employee + Family	$ 1,660.89	$ 1,733.88

Medical Benefits – UnitedHealthcare

After 1 Year of employment, employees who have qualified as full-time employees based on the hours worked in the previous 12 months, have the option to remain enrolled in the before mentioned AllyHealth plans or can select from one of the 4 options below.

MEDICAL	NEXUS PPO EI-4O [2]		NEXUS PPO EI-4N [2]	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual/ Family)	$2,000/$4,000	$5,000/$10,000	$1,000/$2,000	$5,000/$10,000
Co-Insurance (You Pay)	0% (Nexus) / 20% (In-Network)	30%	0% (Nexus) / 20% (In-Network)	30%
Out-of-Pocket (Individual/ Family)	$5,000/$10,000	$10,000/$20,000	$4,000/$8,000	$10,000/$20,000
Office Visit (PCP)	$10 Co-Pay (Nexus) / Child < 19: $0 (Nexus) / $40 Co-Pay (In-Network)	Deductible + 30%	$10 Co-Pay (Nexus) / Child < 19: $0 (Nexus) / $40 Co-Pay (In-Network)	Deductible + 30%
Office Visits (Specialist)	$40 Co-Pay (Nexus) / $100 Co-Pay (In-Network)	Deductible + 30%	$40 Co-Pay (Nexus) / $100 Co-Pay (In-Network)	Deductible + 30%
Preventive Care*	$0	Deductible + 30%	$0	Deductible + 30%
Virtual Visits	$0 Designated Virtual Network Provider	Not Covered	$0 Designated Virtual Network Provider	Not Covered
Urgent Care	$50 Co-Pay	Deductible + 30%	$50 Co-Pay	Deductible + 30%
Emergency Room	$300 Co-Pay/Visit + Deductible		$300 Co-Pay/Visit + Deductible	

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** Age Specifications and Frequency Limitations apply / Refer to your summary plan description for details on how specific services are covered.*

All Nexus Plans - Please note additional facility fees may apply prior to your deductible being met should you choose to utilize a facility that is not affiliated with Baylor Scott & White. Lower costs will apply when visiting a designated Tier 1 provider.

Prescriptions (In-Network)	Nexus PPO EI-4O [2]	NEUXS PPO EI-4N [2]
Tier 1 (30-Day Supply)	$15 Co-Pay	$15 Co-Pay
Tier 2 (30-Day Supply)	$40 Co-Pay	$40 Co-Pay
Tier 3 (30-Day Supply)	$75 Co-Pay	$75 Co-Pay
Specialty Medications	Same as other Medications	Same as other Medications
Mail Order	2.5 X Co-Pay for up to a 90-Day Supply UHC's Mail Order Pharmacy is OptumRX	

Monthly Medical Premiums	Nexus PPO EI-4O [2]	NEUXS PPO EI-4N [2]
Employee Only	$ 625.69	$ 707.28
Employee + Spouse	$ 1,684.78	$ 1,871.37
Employee + Child(ren)	$ 1,116.56	$ 1,246.05
Employee + Family	$ 2,553.08	$ 2,794.89

Visit with a doctor 24/7 — whenever, wherever

With a Virtual Visit, you can talk—by phone[1] or video—to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.[2]

Virtual Visits may make it easier than ever to get treated by a doctor

Whether using **myuhc.com®** or the UnitedHealthcare® app, Virtual Visits let you video chat with a doctor 24/7—without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can simply do a Virtual Visit over the phone. **With a UnitedHealthcare plan, your cost for a Virtual Visit is $49 or less.[3]**

Use a Virtual Visit for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a Virtual Visit—bringing a potential $2,000[4] cost down to $49.

Get started

This applies to members enrolled on the HSA Plan

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**

Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a Virtual Visit is subject to change at any time.

[4] Source 2019: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,000.00 difference between the average emergency room visit and the average urgent care visit.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company and its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

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Use a Virtual Visit for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$0 cost

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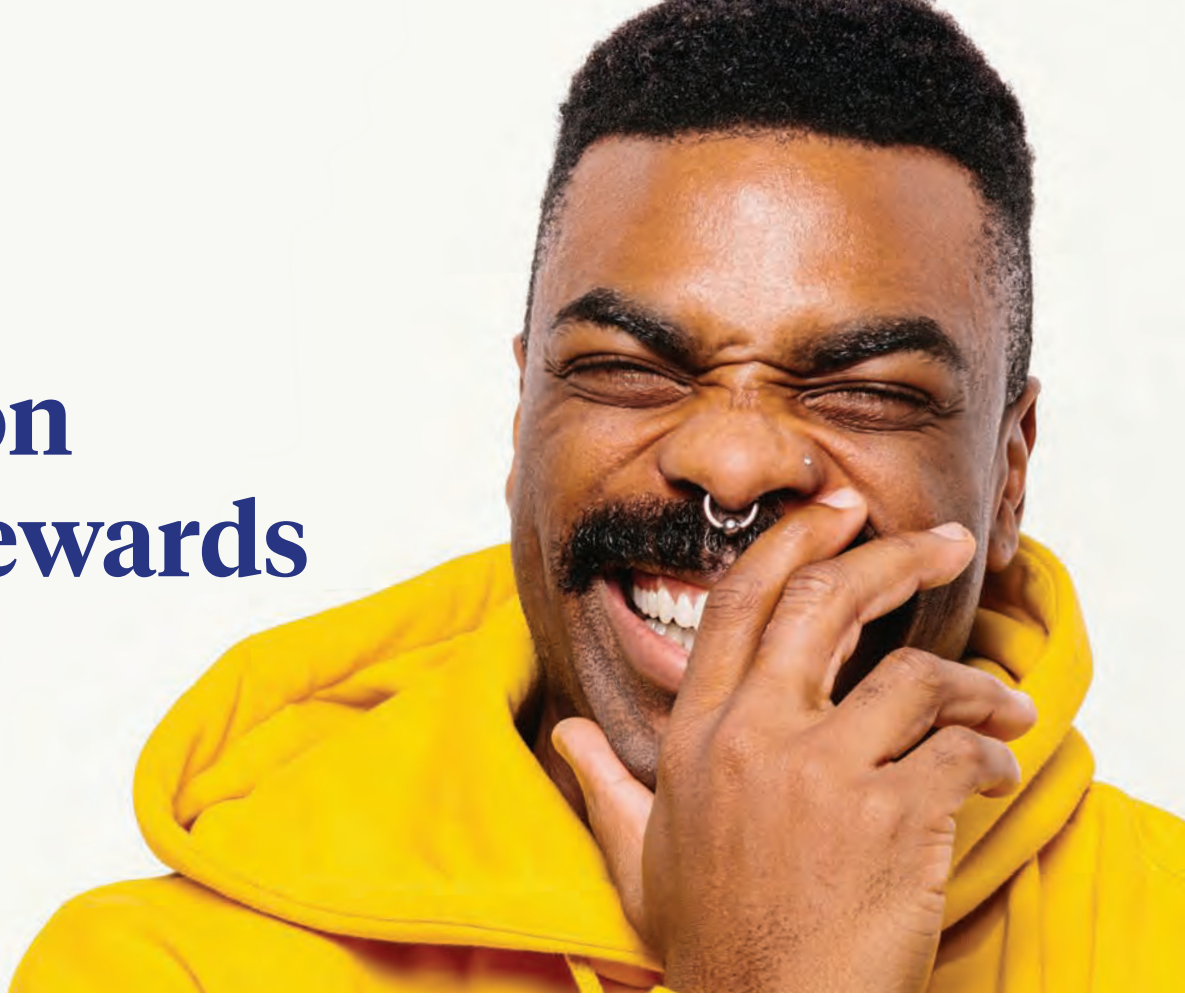
Insurance coverage provided by or through UnitedHealthcare Insurance Company and its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Get in on UHC Rewards



UnitedHealthcare Rewards is a digital experience where you can earn up to $300 for reaching program goals and completing one-time reward activities. And get this: It's included in your health plan at no additional cost. The activities you go for are up to you—same goes for ways to spend your earnings.

There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you—and look for new ways of earning rewards to be added throughout the year.

Earn up to

$300

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Me** tab and choose **Rewards**
- Activate Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **Rewards**
- Activate Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 and use it however you want

Please note tax implications could apply when redeeming rewards, please consult with a tax professional.

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code

United Healthcare | Real Appeal®

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

 WF8689358 222420A-102022 OHC

When life gets challenging, you've got caring, confidential help

Your Employee Assistance Program (EAP) provides support and resources to help you, and your family, with a range of issues, including:

- Managing stress, anxiety and depression
- Improving relationships at home or work
- Getting guidance on legal and financial concerns
- Coping with occupational stress and burnout support
- Addressing substance use issues

This service is provided to you at no additional cost.

$0

Call today for access to EAP resources at no additional cost

EAP provides coverage for 3 free counseling sessions per incident, per year.

Services are completely confidential and will not be shared with your employer.

Get started – call EAP 24/7 at **1-888-887-4114**

United Healthcare

Questions about your health plan? We've got answers.

Help is just a call away

Whether you have questions about a new claim, need to find a doctor or just want to better understand your benefits, our Advocates are here to help. Connect with our team for help finding care for your needs, walking through a bill, accessing additional plan resources and more.

We simplify the health care experience to help you:

- Understand your benefits and claims
- Learn more about your prescriptions*
- Get answers about a bill or payment
- Find support if you have a child with complex needs**
- Locate care and cost options
- Discover your plan's health and well-being benefits

We're dedicated to giving you the information you need to get the most out of your benefits—and your health.

Care whenever you need it

Try 24/7 Virtual Visits to speak with a doctor anytime, from virtually anywhere, using a mobile device or computer. To get started, sign in at **myuhc.com®.**

Connect with us

Call the number on your health plan ID card or sign in to **myuhc.com** and click on **Call** or **Chat**

United Healthcare

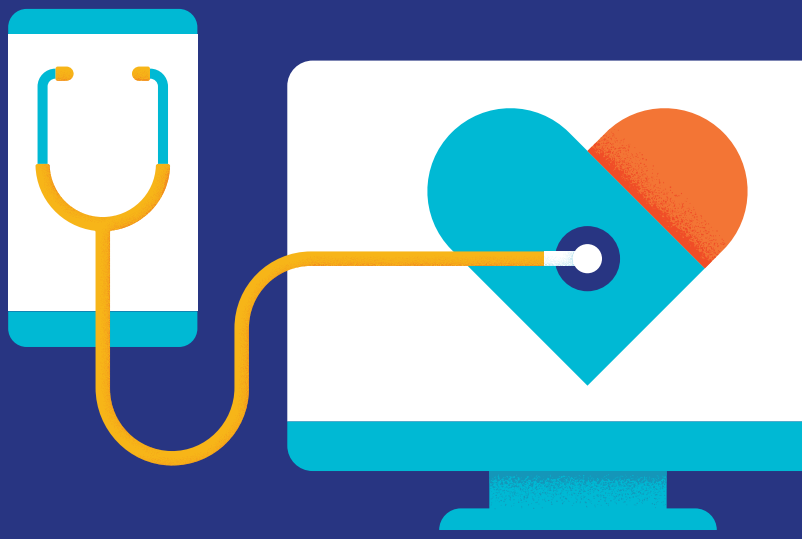
*For members with OptumRx®.

**Qualifying members are eligible for our Special Needs Initiative program; eligibility criteria can be determined by calling the number on your health plan ID card.

This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the program is for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance company and may be discontinued at any time. Additionally, if there is any difference between the information and your coverage documents (Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments), your coverage documents govern.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by or through a UnitedHealthcare company.



Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

UnitedHealthcare

Activation is quick

1. Go to **myuhc.com > Register Now**
2. Fill out the required fields and create your username/password
3. Enter your contact information and security questions
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

Get started at myuhc.com

United Healthcare

[1] UnitedHealthcare Internal Claims Analysis, 2019.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

One Pass Select™

Flexible fitness options for all

With One Pass Select, our mission is to make being healthy fun for all. No matter your current fitness level, we have a wide variety of activities to challenge you and your eligible family members (18+). From strength training and swimming, to yoga and spin classes, you can try new things and push yourself physically and mentally. And that's not all. Get access to digital fitness apps to make it even more convenient to become a better you.

Starting on July, 1, 2024, you and your eligible family members (18+) can get started with One Pass Select when you activate UnitedHealthcare Rewards. Plus, you can use your earnings to help pay for your One Pass Select membership.

Find your fit with One Pass Select

At the gym

Choose from our large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

At home

Work out at home with live or on-demand online fitness classes. Try our workout builder to get routines created just for you, no matter what your fitness level and interests are.

$29/Mo

Classic

11,000+ gym locations

$64/Mo

Standard

13,000+ gym and premium locations

$99/Mo

Premium

15,000+ gym and premium locations

$144/Mo

Elite

17,000+ gym and premium locations

Enrollment information coming soon!

An enrollment fee may apply.

Or get started with a digital-only plan for $10/Mo.

United Healthcare

One Pass Select is a voluntary program featuring a subscription based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

Health Savings Account – Optum Bank

If you enroll in the high-deductible health plan, you can contribute pre-tax dollars to your health savings account up to the IRS annual maximum. Not paying taxes on these contributions can mean savings of 15-25% depending on your tax bracket.

An HSA Account is meant to help save for medical, dental and vision expenses not only this year but for the future. The money in the account rolls over every year and may gain interest. You may also choose to invest the funds in your account. Should you leave the company, you can take the account with you, the money is yours!

Eligibility for the HSA

The main requirement for opening an HSA is having a high-deductible health plan that meets IRS guideline for the annual deductible and out-of-pocket maximum. To be an eligible individual and qualify for an HSA, you must also meet the following requirements.

- You are not covered by a non-HDHP health plan (such as a spouse's plan) or Medicare.
- You do not receive health benefits under Tricare.
- You cannot be claimed as a dependent on another person's tax return.
- You are not covered by a general-purpose health care flexible spending account (FSA) or health reimbursement account (HRA).

Health Savings Account (HSA) Limits	2026 Max Contribution
Employee Only	$4,400
Employee + 1 Dependent	$8,750
Catch-Up Contributions (For those 55 and older, not enrolled in Medicare)	Additional $1,000

Please note you must be enrolled in the HSA EPO EI-48 plan to contribute to the Health Savings Account.

Using Your HSA

You may use funds in your health savings account to pay for an IRS-qualified medical expense (including dental and vision care). This may include expenses that apply toward your deductible, co-insurance or even co-pays. Funds in the account can be used for yourself or any qualifying relative as defined by the IRS; the qualifying relative does not have to be enrolled on the high-deductible health plan. For a complete list of IRS-qualified medical expenses, visit irs.gov.

If the IRS-qualified medical expenses were incurred after your HSA was established, you can pay them or reimburse yourself with HSA funds at any time. You DO NOT have to submit receipts or show documentation of your expenses to the company to use your HSA. However, it is important that you keep sufficient records in the event you are audited by the IRS. Should you choose to take money out of your HSA for ineligible expenses, the IRS will tax these withdrawals and assess a 20% penalty.

Voluntary Dental Benefits – Renaissance

Dental Plan	Dental PPO
Calendar Year Maximum	$1,500 Calendar Year Maximum Per Individual
Deductible (Applies to Basic & Major Services)	$50 Individual, up to 3 per family
Preventive (i.e., Cleanings)	100%
Basic Services (i.e., Fillings)	80%, after deductible
Major Services (i.e., Crowns)	50%, after deductible
Out-of-Network Benefits	Charges will be paid for only up to 90% of the usual and customary amount for dentists in the geographic area, any additional charges will be the responsibility of the patient.

Monthly Dental Premiums	Dental PPO
Employee Only	$ 33.12
Employee + Spouse	$ 66.24
Employee + Child(ren)	$ 78.29
Employee + Family	$ 124.76

Voluntary Vision Benefits – Renaissance (VSP Choice Network)

Vision Plan	Vision PPO	
	In-Network	Out-of-Network Reimbursements
Vision Exam (Once every 12 Months)	$10 Co-Pay	Up to $45
Lenses (Once every 12 Months) In lieu of contact lenses	$25 Co-Pay	Single Vision – Up to $30 Lined Bifocal – Up to $50 Lined Trifocal – Up to $65 Lenticular Lenses – Up to $100
Frames (One set every 24 Months)	Up to $130 Allowance + 20% off remaining balance	Up to $70
Contact Lenses (Once every 12 Months) In lieu of lenses and frames	Elective – Up to $130 Allowance after $60 Co-Pay Medically Necessary – Covered at 100% after $25 Co-Pay	Elective – Up to $105 Medically Necessary – Up to $210

**Co-pays may apply prior to Out-of-Network reimbursements*

** Medically Necessary – Prescribed to correct extreme vision problems that cannot be corrected with regular lenses.*

Monthly Vision Premiums	Vision PPO
Employee Only	$ 5.67
Employee + Spouse	$ 11.33
Employee + Child(ren)	$ 12.12
Employee + Family	$ 19.38

Dental and Vision coverage can be elected at any time after you have satisfied your initial new hire period (first of the month following 30-days of employment). These coverages are not dependent on how long you have been employed.

When members use a Preferred/Participating Provider, they avoid balance billing other than applicable deductibles, coinsurance and/or copayment and out-of-pocket maximums. Reimbursement for out-of-network services may be based on a "reasonable and customary (R&C)" or "usual, customary, and reasonable (UCR)", such as 80% of R&C or 80% of UCR, or as stated above, based on some percentage (110%-150%) of Medicare. Because there is no contract between the plan and the non-participating provider, the non-participating provider is not obligated to accept the plan's allowance as "reasonable and customary" and may bill the member for any balance. Please note, these differentials can be substantial.

This document is an outline of the coverage(s) proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverage(s), exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This document is not a contract and offers no contractual obligation on behalf of SCA.

The intent of this document is to provide you with general information regarding the status of and/or potential concerns related to your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area. This Benefit Enrollment Guide highlights recent plan design changes and is intended to fully comply with the requirement under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description(s).

Important Notices Regarding your Health Coverage

Alto Operations Texas, LLC is providing these important notices to you at no fee. The notices in this package describe important rights that you have under the terms of the Alto Operations Texas, LLC Group Health Plan.

HIPAA SPECIAL ENROLLMENT NOTICE

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 within 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 within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact HR at 888.307.0174.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Employment Assistance under Medicare or CHIP: If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

All questions about Special Enrollment should be directed to HR at 888.307.0174.

WHCRA (Women's Health and Cancer Rights Act) Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the plan's deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator 888.307.0174.

WHCRA (Women's Health and Cancer Rights Act) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 888.307.0174 for more information.

Newborns' Disclosure Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Section 125 Premium Pre-Tax Notice

Each year you may choose to participate in or waive benefits. Your premiums for the benefits selected will automatically be deducted from your salary on a pre-tax basis. If you do not want your wages reduced on a pre-tax basis, contact human resources in writing on or before the start of the plan year on January 1st to request to pay premiums on an after-tax basis. Plan elections and pre-tax premium deductions (including any increases in premium) will automatically carry over for subsequent years. If your required contributions for elected benefits increase or decrease while this agreement remains in effect, your salary deduction will automatically be adjusted to reflect that increase or decrease.

Alto Operations Texas, LLC will provide you with information on the current premium amounts for each plan. If you need to know your current plan elections, contact HR at 888.307.0174.

Availability of HIPAA Notice of Privacy Practices

Alto Operations Texas, LLC Wrap Benefit Plan
Protecting your Health Information Privacy Rights
January 1, 2026

Alto Operations Texas, LLC is committed to the privacy of your health information. The administrators of the Alto Operations Texas, LLC Wrap Benefit Plan ("Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting HR at 888.307.0174.

Important Notice from Alto Operations Texas, LLC 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 Alto Operations Texas, LLC Group Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. Alto Operations Texas, LLC has determined that the prescription drug coverage offered by the Alto Operations Texas, LLC Group Health 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 Alto Operations Texas, LLC coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Alto Operations Texas, LLC coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Alto Operations Texas, LLC 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) if 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 Alto Operations Texas, LLC 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2026
Name of Entity/Sender: Alto Operations Texas, LLC
Contact – Human Resources
Address: 141 Manufacturing St, Ste 100, Dallas, TX 75207
Phone Number: 888.307.0174

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
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	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

UnitedHealthcare **Insurance NexusACO OA EI48 / 2V**

Coverage For: Family | Plan Type: EP1

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?	Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,500** Individual / **$13,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	Designated Network: No copay per visit Network: 20% coinsurance	Not Covered	Virtual Visits - No copay **by a Designated Virtual Network Provider.**
	Specialist visit	Designated Network: No copay per visit Network: 20% coinsurance	Not Covered	None
	Preventive care/ screening/ immunization	No copay per visit	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No copay per service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No copay per service	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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: $10 Mail-Order: $25	Not Covered	Provider 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 Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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 plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible.
	Tier 2 - Your Mid-Range Cost Option	Retail: $35 Mail-Order: $87.50	Not Covered	
	Tier 3 - Your Mid-Range Cost Option	Retail: $60 Mail-Order: $150	Not Covered	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated Network: No copay per visit Network: You pay a $250 per occurrence copay per visit per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	Not Covered	$250 per occurrence copay applies in-network prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers.

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)	
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	No copay per visit	*No copay per visit	*Network deductible applies.
	Emergency medical transportation	No copay per transport	No copay per transport	None
	Urgent Care	No copay per visit	Not Covered	Virtual Visits - No copay **by a Designated Virtual Network Provider.** If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	Not Covered	$500 per occurrence copay applies in-network prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers.
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copay per visit	Not Covered	Network Partial hospitalization/intensive outpatient treatment: No copay See your policy or plan document for additional information about EAP benefits.
	Inpatient services	No copay	Not Covered	See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No copay per visit	Not Covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Designated Network: No copay per visit Network: 20% coinsurance	Not Covered	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	Not Covered	$500 per occurrence copay applies in-network prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers.
If you need help recovering or have other special health needs	Home health care	No copay per visit	Not Covered	Limited to 60 visits per calendar year.
	Rehabilitation services	No copay per visit	Not Covered	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitative services	No copay per visit	Not Covered	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.

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)	
	Skilled nursing care	No copay	Not Covered	Limited to 60 days per calendar year, combined with inpatient rehabilitation and residential treatment.
	Durable medical equipment	No copay per device	Not Covered	Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice services	No copay	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Glasses	• Private duty nursing
• Bariatric surgery	• Infertility Treatment	• Routine Eye Care
• Cosmetic Surgery	• Long Term Care	• Routine foot care - Except as covered for Diabetes
• Dental Care	• Non-emergency care when traveling outside - the US	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic (manipulative) care - 20 visits per calendar year	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.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.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$5,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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:	
Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,070

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

The plan's overall deductible	$5,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,700

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

The plan's overall deductible	$5,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UnitedHealthcare **Insurance NexusACO OAP EI4H / G58S**

Coverage For: Family | Plan Type: PS1

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?	Network: **$6,000** Individual / **$12,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$8,150** Individual / **$16,300** Family Out-of-Network: **$20,000** Individual / **$40,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	Designated Network: $15 copay per visit Network: $45 copay per visit	50% coinsurance	Under age 19 - Designated Network visits are covered at No copay. Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $50 copay per visit Network: $125 copay per visit	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No copay per visit	\50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: 20% X-Ray/Diagnostics: 20% coinsurance	Lab Testing: 50% X-Ray/Diagnostics: 50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

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: $10 Mail-Order: $25 Specialty Retail: $10	Retail: $10 Specialty Retail: $10	Provider 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 Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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 plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 Mail-Order: $112.50 Specialty Retail: $150	Retail: $45 Specialty Retail: $150	
	Tier 3 - Your Mid-Range Cost Option	Retail: $80 Mail-Order: $200 Specialty Retail: $500	Retail: $80 Specialty Retail: $500	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated Network: 20% coinsurance Network: You pay a $250 per occurrence copay per visit per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%	You pay a $250 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%	$250 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	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	Emergency room care	You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	*You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	$300 per occurrence copay applies prior to the overall deductible. *Network deductible applies.
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$50 copay per visit	50% coinsurance	Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	Designated Network: 20% coinsurance Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copay per visit	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No copay per visit	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Designated Network: 20% coinsurance Network: 40% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Designated Network: 20% coinsurance Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 40%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$15 copay per visit	50% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.

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)	
	Habilitative services	$15 copay per visit	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation and residential treatment. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Glasses	• Private duty nursing
• Bariatric surgery	• Infertility Treatment	• Routine Eye Care
• Cosmetic Surgery	• Long Term Care	• Routine foot care - Except as covered for Diabetes
• Dental Care	• Non-emergency care when traveling outside - the US	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic (manipulative) care - 20 visits per calendar year	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.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.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$6,000**
- **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:	
Cost Sharing	
Deductibles	**$6,000**
Copayments	**$10**
Coinsurance	**$1,000**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$7,070**

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

- **The plan's overall deductible** **$6,000**
- **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:	
Cost Sharing	
Deductibles	**$300**
Copayments	**$400**
Coinsurance	**$0**
What isn't covered	
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** **$6,000**
- **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:	
Cost Sharing	
Deductibles	**$2,200**
Copayments	**$100**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,300**

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UnitedHealthcare **Insurance NexusACO OAP EI4O / IU**

Coverage For: Family | Plan Type: PS1

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?	Network: **$2,000** Individual / **$4,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$5,000** Individual / **$10,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	Designated Network: $10 copay per visit Network: $40 copay per visit	30% coinsurance	Under age 19 - Designated Network visits are covered at No copay. Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $40 copay per visit Network: $100 copay per visit	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No copay per visit	\30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: No copay per service X-Ray/Diagnostics: $40 copay per service	Lab Testing: 30% X-Ray/Diagnostics: 30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	$40 copay per service	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

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 Mail-Order: $37.50	Retail: $15	Provider 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 Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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 plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $40 Mail-Order: $100	Retail: $40	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 Mail-Order: $187.50	Retail: $75	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated Network: No copay per visit Network: You pay a $250 per occurrence copay per visit per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $250 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$250 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible .	*You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible .	$300 per occurrence copay applies prior to the overall deductible. *Network deductible applies.
	Emergency medical transportation	No copay per transport	*No copay per transport	*Network deductible applies.
	Urgent Care	$50 copay per visit	30% coinsurance	Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copay per visit	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: No copay See your policy or plan document for additional information about EAP benefits.
	Inpatient services	No copay	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No copay per visit	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	No copay per visit	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$10 copay per visit	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.

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)	
	Habilitative services	$10 copay per visit	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	No copay	30% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation and residential treatment. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	No copay per device	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	No copay	30% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Glasses	• Private duty nursing
• Bariatric surgery	• Infertility Treatment	• Routine Eye Care
• Cosmetic Surgery	• Long Term Care	• Routine foot care - Except as covered for Diabetes
• Dental Care	• Non-emergency care when traveling outside - the US	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic (manipulative) care - 20 visits per calendar year	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.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.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$2,000
Specialist copay	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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:	
Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,070

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

The plan's overall deductible	$2,000
Specialist copay	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$0
What isn't covered	
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	$2,000
Specialist copay	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,100

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UnitedHealthcare Insurance NexusACO OAP EI4N / IU

Coverage For: Family | Plan Type: PS1

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?	Network: **$1,000** Individual / **$2,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,000** Individual / **$8,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	Designated Network: $10 copay per visit Network: $40 copay per visit	30% coinsurance	Under age 19 - Designated Network visits are covered at No copay. Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $40 copay per visit Network: $100 copay per visit	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No copay per visit	\30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: No copay per service X-Ray/Diagnostics: $40 copay per service	Lab Testing: 30% X-Ray/Diagnostics: 30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	$40 copay per service	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

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 Mail-Order: $37.50	Retail: $15	Provider 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 Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. 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 plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $40 Mail-Order: $100	Retail: $40	
	Tier 3 - Your Mid-Range Cost Option	Retail: $75 Mail-Order: $187.50	Retail: $75	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Designated Network: No copay per visit Network: You pay a $250 per occurrence copay per visit per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $250 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$250 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible .	*You pay a $300 per occurrence copay per visit per visit prior to and in addition to paying any Annual Deductible .	$300 per occurrence copay applies prior to the overall deductible. *Network deductible applies.
	Emergency medical transportation	No copay per transport	*No copay per transport	*Network deductible applies.
	Urgent Care	$50 copay per visit	30% coinsurance	Virtual Visits - No copay by a Designated Virtual Network Provider. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copay per visit	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: No copay See your policy or plan document for additional information about EAP benefits.
	Inpatient services	No copay	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No copay per visit	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Designated Network: No copay per visit Network: 20% coinsurance	30% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Designated Network: No copay Network: You pay a $500 Inpatient Stay per occurrence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%	You pay a $500 Inpatient Stay per occurence copay prior to and in addition to paying any Annual Deductible and any coinsurance amount. 30%	$500 per occurrence copay applies prior to the overall deductible. The per occurrence deductible does not apply to Designated Network providers. Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	No copay per visit	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$10 copay per visit	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.

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)	
	Habilitative services	$10 copay per visit	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	No copay	30% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation and residential treatment. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	No copay per device	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	No copay	30% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Glasses	• Private duty nursing
• Bariatric surgery	• Infertility Treatment	• Routine Eye Care
• Cosmetic Surgery	• Long Term Care	• Routine foot care - Except as covered for Diabetes
• Dental Care	• Non-emergency care when traveling outside - the US	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic (manipulative) care - 20 visits per calendar year	• Hearing aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.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.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copay	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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:	
Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,070**

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	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$0
What isn't covered	
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	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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