UnitedHealthcare®

Benefit Summary

Choice Plus Gold 1750
Maryland - Choice Plus
Choice Plus Direct - Plan BOYS

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the UnitedHealthcare Choice Plus Direct Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care from anyone in or out of our network, but you can save more money when you use the network. You can save even more when you use Tier 1 providers.

> **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$25	$1,750	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

> This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	$1,750 per year	$4,000 per year
Medical Deductible - Family	$3,500 per year	$8,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.	Included in your medical deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$6,500 per year	$10,000 per year
Out-of-Pocket Limit - Family	$13,000 per year	$20,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	$50 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance:	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
Non-Emergency Ambulance:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Blood and Blood Products		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Case Management Services		
	The amount you pay is based on where the covered health care service is provided.	
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is required.
Chiropractic Services		
Limited to 20 visits per condition per year.	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Controlled Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to eight per 12 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to two times per 12 months.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.	Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met.	You pay nothing, after the network medical deductible has been met.
Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office.	20% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office.
	$250 per occurrence deductible per date of service; after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.
	Prior Authorization is required.	Prior Authorization is required.
Detoxification Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	$50 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided. Diabetes test strips are not subject to the Annual Deductible, Co-insurance or Co-payment.	
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and Prescription Drug Products. Diabetes test strips are not subject to Annual Deductible, Co-insurance or Co-payment.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.
Emergency Health Care Services - Outpatient		
	$250 per occurrence deductible per visit; after the medical deductible has been met.	$250 per occurrence deductible per visit; after the network medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Family Planning Services		
	$25 co-pay per visit for a primary care physician office visit. A deductible does not apply. $50 co-pay per visit for a specialist office visit. A deductible does not apply. See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products.	20% co-insurance, after the medical deductible has been met. See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient:	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows: Unlimited for Covered Persons up to age 19. For Covered Persons age 19 or older, limited to: 30 visits of physical therapy per condition. 30 visits of occupational therapy per condition. 30 visits of speech therapy per condition.	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain Inpatient services.
Hearing Aids		
Limited to one hearing aid per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Home Health Care		
Note: Home Health Care visits that are provided according to the benefit described in Section 1 of the COC are not subject to the Annual Deductible or Co-insurance. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Infertility Services		
	You pay nothing, after the medical deductible has been met. Prior Authorization is required.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient:	Designated Network: You pay nothing. A deductible does not apply. Network: You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.
Lymphodema Services		
	The amount you pay is based on where the covered health care service is provided.	
Major Diagnostic and Imaging - Outpatient		
	You pay nothing, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. $250 per occurrence deductible per service; after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.	20% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center. Prior Authorization is required.
Medical Foods		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Outpatient:	$50 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Nutritional Services and Medical Nutrition Therapy		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	$25 co-pay per visit for a primary care physician office visit. A deductible does not apply. $50 co-pay per visit for a specialist office visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy		
Limited per year as follows: 90 visits of cardiac rehabilitation per therapy (physical, speech, occupational). 30 visits of physical therapy per condition. 30 visits of occupational therapy per condition. 30 visits of speech therapy per condition. One program per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy for pulmonary rehabilitation therapy.	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. $250 per occurrence deductible per date of service; after the medical deductible has been met for services provided at an outpatient hospital-based center.	20% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 100 days per year when admitted to a Skilled Nursing Facility.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	You pay nothing, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. $250 per occurrence deductible per date of service; after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.	20% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center. Prior Authorization is required for certain services.
Surgical Morbid Obesity Treatment		
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Prior Authorization is required.
Telehealth Services		
	The amount you pay is based on where the covered health care service is provided.	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$10 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Exam Limited to once per year.	$25 co-pay per visit. A deductible does not apply.	20% co-insurance, after the medical deductible has been met.
Eyeglass Lenses Limited to once every 12 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.		
Eyeglass frames with a retail cost up to $130.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Low Vision Care Services Limited to comprehensive low vision exam once every 5 years, including 4 follow-up visits in any 5-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.	20% co-insurance for Low Vision Testing, after the medical deductible has been met. 25% co-insurance for Low Vision Therapy, after the medical deductible has been met.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

For Internal Use only:

MDWAB35BOYS20

Item#	**Rev. Date**	
515-13133	1019_rev02	Base/Value POST/Sep/Emb/45706/2018

UnitedHealthcare Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

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

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 phone number listed on your ID card, 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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 ở mặt sau thẻ hội viên của quý vị.

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

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

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

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

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 sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

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

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

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

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

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 ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

THIS PAGE INTENTIONALLY LEFT BLANK

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Maryland Plan 816

Standard Drugs: 10/40/75 Specialty Drugs: 10/120/150

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Out-of-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges, Ancillary Charges and Coupons.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage shall prevail.

MAMSI Life and Health Insurance Company

Tier Level	Up to 31-day supply			Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Non-Preferred Specialty Network Pharmacy**	**Retail Out-of-Network Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy****
Tier 1 Prescription Drug Products	**$10**	**Not Applicable**	**$10**	**$20**
Tier 1 Specialty Prescription Drug Products	**$10**	**$20**	**$10**	**Not Covered*****
Tier 2 Prescription Drug Products	**$40**	**Not Applicable**	**$40**	**$80**
Tier 2 Specialty Prescription Drug Products	**$120**	**$240**	**$120**	**Not Covered*****
Tier 3 Prescription Drug Products	**$75**	**Not Applicable**	**$75**	**$150**
Tier 3 Specialty Prescription Drug Products	**$150**	**$300**	**$150**	**Not Covered*****

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information.

** You will be charged a retail Co-payment and/or Co-insurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

**Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies in section 10 of your Certificate of Coverage.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or Prescription Drug Product first. You may find out whether a Pharmaceutical Product is subject to step therapy requirements by contacting us at myuhc.com® or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com® or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you may be subject to the Out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com® or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your COC and SBN for additional exclusions and limitations that may apply.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for such Prescription Drug Product. However, we will provide coverage for a New Prescription Drug Product if, in the judgment of the Authorized Prescriber: there is no equivalent Prescription Drug Product on the Prescription Drug List; or an equivalent Prescription Drug Products on the Prescription Drug List has been ineffective in treating a Covered Person's disease or condition; or has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for such Prescription Drug Product. However, we will provide coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber: the excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or the covered Prescription Drug Product on the Prescription Drug List has been ineffective in treating a Covered Person's disease or condition; or has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. However, we will provide coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber: the over-the-counter is not equivalent to the Prescription Drug Product on the Prescription Drug List; or an equivalent over-the-counter drug has been ineffective in treating a Covered Person's disease or condition; or has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used solely for cosmetic purposes.
- Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for such Prescription Drug Product. However, we will provide coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber: the over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or an equivalent over-the-counter drug has been ineffective in treating a Covered Person's disease or condition, or has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of Sickness or Injury, except medical food for Covered Persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

MAMSI Life and Health Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

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

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 phone number listed on your ID card, 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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 ở mặt sau thẻ hội viên của quý vị.

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

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

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

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

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 sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

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

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

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

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jiik'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jiik'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 telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

THIS PAGE INTENTIONALLY LEFT BLANK