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Call our Customer Care team for VMware at 1-844-562-6290, Monday – Friday 8am – 8pm



Benefit Summary

ASO Choice Plus
VMware Medical Plan Name: Traditional Plan

This document is provided as a sample and does not reflect actual benefits. A customized Benefit Summary or Summary Plan Description (SPD) will be created during implementation of the business.

United HealthCare Services, Inc. and VMware want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**[®] - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

VMware also partners with Grand Rounds for members to have access to 2nd/3rd opinions. For more information please contact Grand Rounds at 1-800-929-0926 or visit Grandrounds.com

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.

- No one in the family is eligible for benefits until the family coverage deductible is met.

Medical Deductible – Individual	\$500 per year.	\$500 per year.
Medical Deductible - Family	\$1,500 per year.	\$1,500 per year.

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.

- If more than one person in a family is covered under the Policy, the individual out-of-pocket limit does not apply.
- Your, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit – Individual	\$3,000 per year	\$6,900 per year
Out-of-Pocket Limit – Family	\$9,000 per year	\$20,700 per year

Additional Information

What is a 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.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

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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	Does a Medical Deductible Apply?
Ambulance Services			
Emergency Ambulance:	10% co-insurance	Same as Network.	Network: Yes Out-of-Network: Yes
Non-Emergency Ambulance:	10% co-insurance	10% co-insurance	Network: Yes Out-of-Network: Yes
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.	
Clinical Trials			
	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
	Prior Authorization is required.	Prior Authorization is required.	
Congenital Heart Disease (CHD) Surgeries			
	Benefits will be the same as stated under Hospital - Inpatient Stay.	Out-of-Network Benefits are not available.	Deductible will be the same as stated under Hospital - Inpatient Stay.
		Prior Authorization is required.	
Dental Services – Accident Only			
	\$30/\$45 copay	\$45 copay	Network: Yes Out-of-Network: Yes
	Prior Authorization is required.	Prior Authorization is required.	
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.		Deductible will be based on where the covered health care service is provided.
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 or in the Outpatient Prescription Drug Rider.	Prior Authorization is required for DME that costs more than \$1,000.	
Durable Medical Equipment (DME) , Orthotics and Supplies			
Limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for DME or orthotics that costs more than \$1,000.	
Emergency Health Services - Outpatient			
	10% co-insurance After \$100 co-pay per visit	Same as Network.	Network: No Out-of-Network: No
		Notification is required if confined in an Out-of-Network Hospital.	
Gender Dysphoria			
	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.	
Habilitative Services			
Inpatient:	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.			
Outpatient:	\$45 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy.			
For the above outpatient therapies: Limits will be the same as, and combined with,			

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.			
		Prior Authorization is required for certain services.	
Hearing Aids			
Limited to \$5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Home Health Care			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	0% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.		Prior Authorization is required.	
Hospice Care			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for Inpatient Stay.	
Hospital – Inpatient Stay			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required.	
Lab, X-Ray and Diagnostics - Outpatient			
Lab Testing - Outpatient	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
X-Ray and Other Diagnostic Testing - Outpatient	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Major Diagnostic and Imaging - Outpatient			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Mental Health Care and Substance – Related and Addictive Disorders Services			
Inpatient:	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Outpatient:	\$30 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance	30% co-insurance	Network: No Out-of-Network: Yes
		Prior Authorization is required for certain services.	
Ostomy Supplies			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Pharmaceutical Products - Outpatient			
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home. Infusion Therapy covered 100% deductible	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
waived both innetwork and out of network			
Physician Fees for Surgical and Medical Services			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Physician's Office Services – Sickness and Injury			
Primary Care Physician Office Visit:	\$30 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Specialist Office Visit:	\$45 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
		Prior Authorization is required for Genetic Testing.	
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office.			
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.	Deductible will be based on where the covered health care service is provided.
Preventive Care Services			
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing	30% co-insurance.	Network: No Out-of-Network: Yes
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			
Limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		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.	Deductible will be based on where the covered health care service is provided.
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment			
Benefits are limited as follows: Unlimited visits of physical therapy Unlimited visits of occupational therapy 20 visits of Manipulative Treatment per calendar year Unlimited visits of speech therapy Unlimited visits of pulmonary rehabilitation therapy Unlimited visits of cardiac rehabilitation therapy Unlimited visits of post-cochlear implant aural therapy Unlimited visits of cognitive rehabilitation therapy	\$45 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Scopic Procedures – Outpatient Diagnostic and Therapeutic			
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services			
Limited to 120 days per calendar year.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required.	
Surgery – Outpatient			
	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes
		Prior Authorization is required for certain services.	
Therapeutic Treatments – Outpatient			
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, medical education services and radiation oncology.	10% co-insurance	30% co-insurance	Network: Yes Out-of-Network: Yes

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Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
		Prior Authorization is required for certain services.	
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.	The amount you pay is based on where the covered health care service is provided.	Deductible will be based on where the covered health care service is provided.
	Prior Authorization is required.	Prior Authorization is required.	
Urgent Care Center Services			
	\$45 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility.			
Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit 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.	\$20 co-pay per visit	Out-of-Network Benefits are not available.	Network: No Out-of-Network: N/A
Covered Health Care Services			
	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits	Does a Medical Deductible Apply?
Acupuncture Services			
Limited to 20 visits per calendar year.	\$45 co-pay per visit	30% co-insurance	Network: No Out-of-Network: Yes
Infertility Services			
Limited to services provided by Progyny Call 833-851-2238 for care.	10% co-insurance	Out-of-Network Benefits are not available.	Network: Yes Out-of-Network: N/A
	Prior Authorization is required.	.	
Obesity – Weight Loss Surgery			
Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	The amount you pay is based on where the covered health care service is provided.	Out-of-Network Benefits are not available.	Deductible will be based on where the covered health care service is provided.
	Prior Authorization is required.		
Temporomandibular Joint Services			
Limited to surgical treatment. Non-surgical treatment is not covered.	The amount you pay is based on where the covered health care service is provided.		Deductible will be based on where the covered health care service is provided.
		Prior Authorization is required for Inpatient Stay.	
Wigs			
Coverage is provided for hair loss as result of radiation therapy or chemotherapy or alopecia areata..	10% co-insurance	10% co-insurance	Network: Yes Out-of-Network: Yes

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This is a list of the services your plan generally does NOT cover. Review your Summary Plan Description (SPD), Schedule of Benefits (SBN) 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
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Vision Exams
- Routine Foot Care
- Temporomandibular Joint Services – Non-Surgical
- Weight Loss Programs

**For Internal Use Only:
SFXAB XXTraditional Plan18**

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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 LUU 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.

تنبیه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف 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. لطفاً با شماره تلفن رایگان که روی کارت شناسایی شما درج شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेवाएं, 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: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្រវឹងនិយាយភាសាដើមគិតគិតថ្លៃ គឺមានស្យាបអ្នក។ សម្រាប់សព្វទៅលើខេត្តគិតថ្លៃ ដៃលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánsiti'go, saad bee áka'anida'awo'igii, t'áá jik'eh, bee ná'ahóót'i. T'áá shoqdi nanaaltsos nit'izi bee né'chozinigii bine'déq' t'áá jik'ehgo béesh bee hane'i bíká'igii bee hodiilnah.

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

This Benefit Summary should only be used to highlight your Benefits. Don't use this document to understand your exact coverage, exclusions, and limitations. If this Benefit Summary conflicts with the Summary Plan Description (SPD), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your SPD 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. This material is provided on the recipient's agreement that it will only be used for the purpose of describing United HealthCare Services, Inc.'s products and services to the recipient. Any other use, copying or distribution without the express written permission of United HealthCare Services, Inc. is prohibited.