


**Benefit Summary**  
**ASO Choice Plus**  
**7ME-M 10-1-2020**

Jefferson Township Local Schools Medical Plan

**UnitedHealthcare and EPC 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 much, much 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.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you 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.

**PLAN HIGHLIGHTS**

| Types of Coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Network Benefits                                    | Non-Network Benefits                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| <b>Annual Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     |                                                     |
| Individual Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$100 per year                                      | \$200 per year                                      |
| Family Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$300 per year                                      | \$600 per year                                      |
| <ul style="list-style-type: none"> <li>• Member Copayments do not accumulate towards the Deductible</li> </ul>                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                     |
| <b>Out-of-Pocket Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                     |                                                     |
| Individual Out-of-Pocket Maximum                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$1100 per year                                     | \$1700 per year                                     |
| Family Out-of-Pocket Maximum                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$2300 per year                                     | \$3600 per year                                     |
| <ul style="list-style-type: none"> <li>• The Out-of-Pocket Maximum includes the Annual Deductible.</li> <li>• Member Copayments and co-insurance do accumulate towards the Out-of-Pocket Maximum.</li> </ul>                                                                                                                                                                                                                                                                            |                                                     |                                                     |
| <b>Benefit Plan Coinsurance – The Amount the Plan Pays</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 90% after Deductible has been met for most services | 70% after Deductible has been met for most services |
| <b>Lifetime Maximum Benefit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                     |
| The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan                                                                                                                                                                                                                                                                                                                                                                                   | Unlimited                                           |                                                     |
| <b>Prescription Drug Benefits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                     |                                                     |
| <ul style="list-style-type: none"> <li>• Prescription drug benefits are shown under separate cover.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                     |
| <b>Information of Pre-service Notification</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                     |
| *Prior Authorization is required for certain services.                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                     |                                                     |
| **Prior Authorization is required for Equipment in excess of \$1,000 both in and out of network.                                                                                                                                                                                                                                                                                                                                                                                        |                                                     |                                                     |
| <b>Information on Benefit Limits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |                                                     |
| <ul style="list-style-type: none"> <li>• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.</li> <li>• All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.</li> <li>• When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.</li> </ul> |                                                     |                                                     |

**BENEFITS**

| Types of Coverage                                                                                                                                                                                                          | Network Benefits                    | Non-Network Benefits                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------|
| <b>Ambulance Services – Emergency and Non-Emergency</b>                                                                                                                                                                    |                                     |                                             |
|                                                                                                                                                                                                                            | * 90% after Deductible has been met | * 90% after Network Deductible has been met |
| <b>Dental Services – Accident Only</b>                                                                                                                                                                                     |                                     |                                             |
|                                                                                                                                                                                                                            | * 80% after Deductible has been met | * 80% after Network Deductible has been met |
| <b>Durable Medical Equipment (DME)</b>                                                                                                                                                                                     |                                     |                                             |
| Benefits are limited as follows:<br>Benefits are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.<br>Hearing Aids are limited to \$2500 per year. | 80% after Deductible has been met   | ** 50% after Deductible has been met        |

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| <b>BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Types of Coverage                                                                                                                                                                                                                                                                                                                                                                | Network Benefits                                                                                                                                                                                                                                                  | Non-Network Benefits                                                                                                                                      |
| <b>Emergency Health Services - Outpatient</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 100% after you pay a \$100 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead. | * 100% after you pay a \$100 Copayment per visit                                                                                                          |
| <b>Home Health Care</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| Benefits are limited as follows:<br>60 visits per year                                                                                                                                                                                                                                                                                                                           | 90% after Deductible has been met                                                                                                                                                                                                                                 | * 70% after Deductible has been met                                                                                                                       |
| <b>Hospice Care</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 90% after Deductible has been met                                                                                                                                                                                                                                 | * 70% after Deductible has been met                                                                                                                       |
| <b>Hospital – Inpatient Stay</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 100% after you pay a \$250 Copayment per Inpatient Stay                                                                                                                                                                                                           | * 70% after Deductible has been met                                                                                                                       |
| <b>Lab, X-Ray and Diagnostics - Outpatient</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.                                                                                                                                                                                                                                                                                       | 90% after Deductible has been met                                                                                                                                                                                                                                 | 70% after Deductible has been met<br>Prior Authorization is required for sleep studies                                                                    |
| <b>Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine - Outpatient</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 90% after Deductible has been met                                                                                                                                                                                                                                 | 70% after Deductible has been met<br>Prior Authorization is required                                                                                      |
| <b>Mental Health and Substance Abuse Services – Inpatient and Intermediate</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 100% after you pay a \$250 Copayment per Inpatient Stay                                                                                                                                                                                                           | * 70% after Deductible has been met                                                                                                                       |
| <b>Mental Health and Substance Abuse Services – Outpatient</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | * 100% after you pay a \$20 Copayment per visit                                                                                                                                                                                                                   | * 70% after Deductible has been met                                                                                                                       |
| <b>Ostomy Supplies</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 80% after Deductible has been met                                                                                                                                                                                                                                 | 50% after Deductible has been met                                                                                                                         |
| <b>Physician Services – Surgical and Medical</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 90% after Deductible has been met                                                                                                                                                                                                                                 | 70% after Deductible has been met                                                                                                                         |
| <b>Physician's Office Services – Sickness and Injury</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| Primary Physician Office Visit                                                                                                                                                                                                                                                                                                                                                   | 100% after you pay a \$20 Copayment per visit                                                                                                                                                                                                                     | 70% after Deductible has been met                                                                                                                         |
| Specialist Physician Office Visit                                                                                                                                                                                                                                                                                                                                                | 100% after you pay a \$20 Copayment per visit                                                                                                                                                                                                                     | 70% after Deductible has been met                                                                                                                         |
| No copayment applies if physician's charge is not assessed.<br>In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Products                                                                                                                                                         |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| <b>Pregnancy – Maternity Services</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary                                                                                         |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.                                                                                                                                                         | Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. |
| <b>Preventive Care Services</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| Covered Health Services include but are not limited to:                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| Primary Physician Office Visit                                                                                                                                                                                                                                                                                                                                                   | 100%                                                                                                                                                                                                                                                              | Non-Network Benefits are not available                                                                                                                    |
| Specialist Physician Office Visit                                                                                                                                                                                                                                                                                                                                                | 100%                                                                                                                                                                                                                                                              |                                                                                                                                                           |
| Lab, X-Ray or other preventive tests                                                                                                                                                                                                                                                                                                                                             | 100% Deductible does not apply.                                                                                                                                                                                                                                   |                                                                                                                                                           |
| <b>Prosthetic Devices</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | 80% after Deductible has been met                                                                                                                                                                                                                                 | 50% after Deductible has been met<br>Prior Authorization is required for Prosthetic Device in excess of \$1000                                            |
| <b>Reconstructive Procedures</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary                                                                                         |                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                   | Prior Authorization is required for certain services.                                                                                                     |
| <b>Rehabilitation Services – Outpatient Therapy and Chiropractic Treatment</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                   |                                                                                                                                                           |
| Benefits are limited as follows:<br>Network and Non-Network benefits are limited to a combined total of 50 visits per calendar year for any combination of the following:<br>Chiropractic treatment<br>Physical therapy<br>Occupational therapy<br>Speech therapy<br>Pulmonary rehabilitation<br>Cardiac rehabilitation<br>Post-Cochlear implant aural therapy<br>Vision therapy | 100% after you pay a \$20 Copayment per visit<br><br>Benefits for Habilitative Services are provided under and as part of Rehabilitation Services-Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated under Rehab Services      | * 70% after Deductible has been met                                                                                                                       |

| BENEFITS                                                                                                                                                                                 |                                                                           |                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------|
| Types of Coverage                                                                                                                                                                        | Network Benefits                                                          | Non-Network Benefits                   |
|                                                                                                                                                                                          |                                                                           |                                        |
| Scopic Procedures – Outpatient Diagnostic and Therapeutic                                                                                                                                |                                                                           |                                        |
| Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy<br>For Preventive Scopic Procedures, refer to the Preventive Care Services category. | 90% after Deductible has been met                                         | 70% after Deductible has been met      |
| Skilled Nursing Facility / Inpatient Rehabilitation Facility Services                                                                                                                    |                                                                           |                                        |
| Benefits are limited as follows:<br>300 days per year. Facility Services are limited to 120 days per incident.                                                                           | 90% after Deductible has been met                                         | * 70% after Deductible has been met    |
| Surgery – Outpatient                                                                                                                                                                     |                                                                           |                                        |
|                                                                                                                                                                                          | 90% after Deductible has been met                                         | 70% after Deductible has been met      |
| Therapeutic Services                                                                                                                                                                     |                                                                           |                                        |
|                                                                                                                                                                                          | 90% after Deductible has been met                                         | 70% after Deductible has been met      |
| Transplantation Services                                                                                                                                                                 |                                                                           |                                        |
|                                                                                                                                                                                          | 80% after Deductible has been met                                         | * Not Covered                          |
|                                                                                                                                                                                          | For Network Benefits, services must be received at a Designated Facility. |                                        |
| Urgent Care Center Services                                                                                                                                                              |                                                                           |                                        |
|                                                                                                                                                                                          | 100% after you pay a \$50 Copayment per visit                             | 70% after Deductible has been met      |
| In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Products                                |                                                                           |                                        |
| Vision Examinations                                                                                                                                                                      |                                                                           |                                        |
| Benefits are limited as follows:<br>1 exam every year                                                                                                                                    | 100% after you pay a \$20 Copayment per visit                             | Non-Network Benefits are not available |

| MEDICAL EXCLUSIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| It is recommended that you 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| <b>Alternative Treatments</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Acupressure; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in the SPD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <b>Dental</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate. |  |
| <b>Devices, Appliances and Prosthetics</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>Drugs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions.<br>Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <b>Experimental or Investigational or Unproven Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>Foot Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>Medical Supplies and Equipment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> <li>• Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.</li> <li>• Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.</li> <li>• Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.</li> </ul> Tubings, nasal cannulas, connectors and masks, [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>Mental Health / Substance Abuse</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Abuse (MH/SA) Administrator; Services performed in connection with conditions not classified in the current edition of the <i>American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders</i> .<br>Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |

prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Administrator. Services utilizing methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements ,unless authorized by the Mental Health/Substance Abuse Administrator. Residential treatment services. Routine use of psychological testing without specific authorization; pastoral counseling. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with:

- Prevailing national standards of clinical practice for the treatment of such conditions.
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time.

The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

## **MEDICAL EXCLUSIONS Continued**

### **Nutrition**

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Nutritional Counseling in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

### **Personal Care, Comfort or Convenience**

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

### **Physical Appearance**

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss ,except for temporary loss of hair resulting from treatment of a malignancy.

### **Procedures and Treatments**

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Chiropractic treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, including oral appliances: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniocacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Diagnosis or treatment of the jawbones, including Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Treatment of tobacco dependency. Chelation therapy, except to treat heavy metal poisoning.

### **Providers**

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.

### **Reproduction**

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

### **Services Provided under Another Plan**

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

### **Transplants**

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

### **Travel**

Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

### **Types of Care**

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

### **Vision and Hearing**

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

### **All Other Exclusions**

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to

HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia



## Addendum to the Medical Benefit Summary for Self-Funded Groups

Jefferson Township - Choice Plus

These Benefits are available to you in addition to the benefits located on the Benefit Summary.

### ADDITIONAL CORE BENEFITS

| Types of Coverage | Network Benefits                                                                                                                                                               | Non-Network Benefits                                         |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Gender Dysphoria  | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the Schedule of Benefits. |                                                              |
|                   |                                                                                                                                                                                | <i>Prior Authorization is required for certain services.</i> |

**This Gender Dysphoria exclusion applies:**

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

**This Procedures and Treatments exclusion no longer applies when Gender Dysphoria applies:**

Sex transformation operations and related services.

### Mental Health Services

|                                                         |                                                                                                            |                                                                                                            |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| Partial Hospitalization/Intensive Outpatient Treatment: | 90% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. | 70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. |
|                                                         |                                                                                                            | <i>Prior Authorization is required for certain services.</i>                                               |

### Neurobiological Disorders – Autism Spectrum Disorder Services

|                                                         |                                                                                                            |                                                                                                            |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| Partial Hospitalization/Intensive Outpatient Treatment: | 90% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. | 70% after Deductible has been met per session for Partial Hospitalization /Intensive Outpatient Treatment. |
|                                                         |                                                                                                            | <i>Prior Authorization is required for certain services.</i>                                               |

### Substance Use Disorder Services

|                                                         |                                                                           |                                                                           |
|---------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Partial Hospitalization/Intensive Outpatient Treatment: | 90% after Deductible has been met per session for Partial Hospitalization | 70% after Deductible has been met per session for Partial Hospitalization |
|---------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|

/Intensive Outpatient Treatment.

/Intensive Outpatient Treatment.

*Prior Authorization is required for certain services.*

#### Virtual Visits

Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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.

100% after you pay a \$20 Copayment per visit. Deductible does not apply.

Non-Network Benefits are not available.

#### **This replaces the Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders exclusion sections on the Benefit Summary:**

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. [Intensive Behavioral Therapies such as Applied Behavior Analysis for Autism Spectrum Disorders.] Transitional Living services.

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This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary Addendum conflicts in any way with the Summary Plan Description (SPF), the SPD shall prevail. It is recommended that you 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.

**SFTGYYYY07**

United HealthCare Services, Inc. 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 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 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 other 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

تنبيه: 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 رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ्री फ़ोन नंबर पर काल करें।

CEEBOOM: 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**ខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខគិតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anida'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i. T'áá shqódí ninaaltsoos nítł'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hódíilnih.

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.



## Medical Benefit Summary Authorization Addendum for Self-Funded Groups Choice Plus

These Prior Authorization requirements shown here will change the Pre-Service Notification requirements indicated on your Benefit Summary.

### Network Benefits

***The following benefit requires [Pre-Service Notification][Prior Authorization] for Genetic Testing - BRCA.***

- Ambulance Services – Non-Emergent Air
- Clinical Trials

### Non-Network Benefits

- Physician's Office Services

***The following benefits require [Pre-Service Notification][Prior Authorization] for certain services.***

- Ambulance Services – Non-Emergent Air
- [Clinical Trials]
- Cochlear Implants]
- [Congenital Heart Disease (CHD) Surgeries]
- Home Health Care - Nutritional, Private Duty Nursing, Skilled Nursing
- Hospice Care- Inpatient Stay
- Hospital – Inpatient Stay
- [Infertility Services]
- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders-Inpatient [and Outpatient]
- Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine
- Mental Health and Substance Abuse Services – Outpatient and] Inpatient
- Reconstructive Procedures
- Skilled Nursing Facility/Inpatient Rehabilitation
- Substance Use Disorder Services-Inpatient [and Outpatient]]
- Surgery for the treatment for Gender Dysphoria]
- Surgery – Outpatient[Sleep Apnea] and Cardiac catheterization, diagnostic cardiac catheterization; cardiac electrophysiology implant, pacemaker insertion, implantable cardioverter defibrillators
- Therapeutic Treatments – Outpatient[Dialysis and IV infusion,] [and radiation oncology,] [and intensity modulated radiation therapy,] [and MR-guided focused ultrasound]]
- Transplantation Services

- Transplantation Services

***The following benefits require [Pre-Service Notification][Prior Authorization] for Sleep Studies.***

- Outpatient Diagnostic Services – For lab and radiology/X-ray

***The following benefit requires [Pre-Service Notification][Prior Authorization] if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.***

- Maternity Services

***The following benefits require [Pre-Service Notification][Prior Authorization] for Equipment in excess of \$1,000.***

- [Diabetes Services]
- Durable Medical Equipment

- Prosthetic Devices

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This Benefit Summary Addendum is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you 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.

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SFEGYYYYY07PA

UPDATED: 8/15/2016

# Here's an overview of your CVS Caremark benefits.

## Jefferson Township PPO - 10/1/2020

If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help any time after your plan starts. For TDD assistance, please call 1-800-863-5488.

|                                                                                                                                                           | <b>Short-Term Medicines</b><br>CVS Caremark Retail<br>Pharmacy Network<br>(Up to a 30-day supply)                                                                                                                                   | <b>Long-Term Medicines</b><br>CVS Caremark Mail Service or<br>CVS Pharmacy locations (up to a<br>90-day supply) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <b>Generic Medicines</b><br>Always ask your doctor if there's a generic option available. It could save you money.                                        | <b>\$10</b> for a generic medicine                                                                                                                                                                                                  | <b>\$20</b> for a generic medicine                                                                              |
| <b>Preferred Brand-Name Medicines</b><br>If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list. | <b>\$25</b> for a preferred brand-name medicine                                                                                                                                                                                     | <b>\$50</b> for a preferred brand-name medicine                                                                 |
| <b>Non-Preferred Brand-Name Medicines</b><br>Drugs that aren't on your plan's preferred list will cost more.                                              | <b>35% (\$45 min / \$60 max)</b> for a non-preferred brand-name medicine                                                                                                                                                            | <b>35% (\$90 min / \$120 max)</b> for a non-preferred brand-name medicine                                       |
| <b>Refill Limit</b>                                                                                                                                       | <b>None</b>                                                                                                                                                                                                                         | <b>None</b>                                                                                                     |
| <b>Maximum Out-of-Pocket</b>                                                                                                                              | <b>\$3,000 per individual / \$6,000 per family</b>                                                                                                                                                                                  |                                                                                                                 |
| <b>Prior Authorization</b>                                                                                                                                | Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit <a href="http://www.caremark.com">www.caremark.com</a> for verification of prior authorization requirements. |                                                                                                                 |
| <b>Specialty Medicines</b>                                                                                                                                | Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.              |                                                                                                                 |

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information.

7471-WKL-MCHOICE\_MOOP\_SP\_CUSTOM-1219

## Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator  
PO BOX 6590, Lee's Summit, MO 64064-6590  
Phone: 1-866-526-4075  
TTY: 1-800-863-5488  
Fax: 1-855-245-2135  
Email: [nondiscrimination@cvscaremark.com](mailto:nondiscrimination@cvscaremark.com)

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

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

**ATTENTION:** If you speak [insert language], language assistance services, free of charge, are available to you. Call Customer Care at the number on your benefit ID card (TTY: 711).

|                |                                                                                                                                                                                                                                                               |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Español        | ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio al cliente al número telefónico que aparece en su tarjeta de identificación de beneficios (TTY: 711).                                      |
| 中文             | 請注意：如果您使用繁體中文，您可以獲得免費的語言協助服務。請撥打您福利身份卡 (Benefit ID Card) 上的電話號碼 (TTY: 711) 致電客服中心。                                                                                                                                                                            |
| Tiếng Việt     | CHU Y: Nếu bạn nói Tiếng Việt, chúng tôi có cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi cho Ban Chăm Sóc Khách Hàng theo số điện thoại có trên thẻ nhận dạng phúc lợi của bạn (TTY: 711).                                             |
| 한국어            | 알림: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본인의 혜택 ID 카드에 표시된 고객 지원 전화번호로 연락 주시기 바랍니다 (TTY: 711).                                                                                                                                                          |
| Tagalog        | PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Customer Care sa numero ng telepono na nasa iyong ID card ng benepisyo (TTY: 711).                                                     |
| Русский        | ВНИМАНИЕ! Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Свяжитесь с Отделом обслуживания клиентов по номеру телефона, указанному на вашей индивидуальной карте для социальных выплат (телетайп: 711).                        |
| العربية        | ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل بفريق دعم العملاء على الرقم الموجود على بطاقة التعريف. (رقم جهاز TTY للصم: 711).                                                                                             |
| Haitian Creole | ATANSYON: Si w pale Haitian Creole, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Kliyan nan nimewo telefòn ki sou kat ID avantajou an (TTY: 711).                                                                                              |
| Français       | ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Service client au numéro de téléphone figurant sur votre carte de prestations (ATS : 711).                                                  |
| Polski         | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy w tym języku. Zadzwoń do Biura Obsługi Klienta, korzystając z numeru podanego na Twojej karcie identyfikacyjnej (TTY: 711).                                                             |
| Português      | ATENÇÃO: se você fala português, também pode obter informações sobre os serviços de assistência nesse idioma, sem nenhum custo adicional. Ligue para o Atendimento ao Cliente usando o número de telefone no seu cartão de beneficiário (TTY: 711).           |
| Italiano       | ATTENZIONE: Nel caso in cui la lingua parlata sia l'italiano, sono disponibili gratuitamente servizi di assistenza linguistica. Contattare l'Assistenza Clienti al numero che compare sulla propria tessera dei benefit identificativa (TTY: 711).            |
| Deutsch        | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Kundenbetreuung unter der Rufnummer auf Ihrer Versicherungskarte an (TTY: 711).                                                     |
| 日本語            | 注：日本語での会話を希望される場合は、無料の言語支援をご利用いただけます。保険カードに記載されているカスタマーケアの電話番号(TTY: 711)へお問い合わせください。                                                                                                                                                                          |
| فارسی          | توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. از طریق شماره تلفن درج شده بر روی کارت شناسایی مزایای تان با بخش پشتیبانی مشتریان تماس بگیرید (TTY: 711)                                                            |
| हिंदी          | ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके बनिफिट आईडी कार्ड पर दिए गए ग्राहक सेवा के फोन नंबर पर कॉल करें (TTY: 711)।                                                                                       |
| Հայերեն        | ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ կարող են տրամադրվել թարգմանչի ծառայություններ: Չանգահարեք Հաճախորդների սպասարկման բաժնի՝ ձեր նպաստների անհատական (ID) քարտի վրա նշված հեռախոսահամարով (TTY: 711).                                               |
| ગુજરાતી        | સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. તમારા બેનીફિટ આઈડી કાર્ડ ઉપરના ફોન નંબર પર કસ્ટમર કેરને કોલ કરો (TTY: 711).                                                                                                 |
| Hmoob          | MLOOG ZOO: Yog koj hais lus Hmoob, peb muaj neeg txhais lus, pub dawb rau koj. Hu rau Cov Neeg Pab Qhua Lag Luam ntawm tus xov tooj nyob hauv koj daim ID siv qhov kev pab no (Rau cov neeg hais tsis tau lus thiab tsis nov lus siv tus xov tooj (TTY: 711). |
| اردو           | خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی معاونت کی خدمات مفت میں دستیاب ہیں۔ اپنے منفعت ائی ڈی کارڈ پر فون نمبر (ٹی ٹی وائی: 711) پر کسٹمر کیئر کو کال کریں۔                                                                                           |
| ខ្មែរ          | យកចិត្តទុកដាក់: បេសជ្ជាអ្នកនយាយ ភាសាខ្មែរ, សេវាកម្មជន្មជួយផ្នែកភាសាដោយគឺគិតកម្រៃមានផ្តល់ជូនសំរាប់លោកអ្នក។ សូមទូរស័ព្ទទៅផ្នែកថែទាំអតិថិជនតាមលេខទូរស័ព្ទនៅលើប័ណ្ណ ID អត្តប្រយោជន៍របស់អ្នក (TTY: 711)។                                                           |

|                 |                                                                                                                                                                                                                                                                 |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ਪੰਜਾਬੀ          | ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਵੱਲੋਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਬੈਨੀਫਿਟ ਆਈਡੀ ਕਾਰਡ ਉੱਪਰ ਦਿੱਤੇ ਗਏ ਕਸਟਮਰ ਕੇਅਰ ਦੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ (TTY: 711)।                                                                                 |
| বাংলা           | লক্ষ্য করুন: আপনি যদি বাংলা ভাষায় কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। কাস্টমার কেয়ারে ফোন করুন আপনার বেনিফিট আইডি কার্ডে দেওয়া (TTY: 711) নম্বর অনুযায়ী।                                                                       |
| שְׂדִי'א        | אופנים: איב איר אידע, אונזערע אונזערע פאר אייך שפראך הייליג וואווינענדיק פון אפצאלן. (TTY: 711) ID קארט.                                                                                                                                                        |
| አማርኛ            | ማስታወሻ:- የአማርኛ ቋንቋ ተናጋሪ ከሆኑ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። በጥቅማጥቅም ካርድዎ ላይ በሚገኘው ስልክ ቁጥር ለደንበኞች አገልግሎት ይደውሉ (መስማት ለተሳናቸው:- 711)።                                                                                                                         |
| ภาษาไทย         | หมายเหตุ: ถ้าคุณพูดภาษาไทย เรามีบริการให้ความช่วยเหลือทางด้านภาษาให้คุณฟรี โทรหาฝ่ายบริการลูกค้าที่หมายเลขโทรศัพท์ที่ระบุอยู่บนบัตรผลประโยชน์ของคุณ (โทร: 711)                                                                                                  |
| Oroomiffa       | XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Karaa lakkoosfa bilbila Kunuunsaa Maamiltootaa waraqaa eenyummaa faayidaa kee irratti argamu (TTY: 711) tiin bilbili.                                      |
| Ilokano         | Pakdaar: No agsasao ka ti Ilocano, dagitti serbisyo nga tulong iti lengguahe nga libre, ket sidadaan para kenka. Tawagan ti Customer Care iti numero ti telepono iti ID card ti benepisyom (TTY: 711).                                                          |
| ພາສາລາວ         | ເລື່ອງສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ແກ່ທ່ານ. ໃຫ້ໂທຫາຝ່າຍດູແລລູກຄ້າຕາມເບີໂທທີ່ລະບຸໄວ້ຢູ່ໃນບັດຜູ້ໄດ້ຮັບຜົນປະໂຫຍດຂອງທ່ານ (ໂທ TTY: 711).                                                                                              |
| Shqip           | KUJDES: Nëse flisni Shqip, shërbimet e asistencës gjuhësore janë në dispozicionin tuaj, pa pagesë. Telefononi Kujdesin për Konsumatorët në numrin e telefonit në kartën tuaj të identifikimit të benefiteve (TTY: 711).                                         |
| Srpsko-hrvatski | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite službu koja brine o korisnicima na broju telefona koji se nalazi na vašoj ID kartici usluga (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711). |
| Українська      | УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте у Відділ обслуговування клієнтів за номером, вказаним на вашій індивідуальній карті для соціальних виплат (Телетайп: 711).              |
| नेपाली          | ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंको लागि नि:शुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको बनिफिट आईडी कार्डमा भएको ग्राहक स्याहारको फोन नम्बर (TTY: 711) मा फोन गर्नुहोस्।                                                            |
| Nederlands      | AANDACHT: Als u Nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel de Klantenservice op het telefoonnummer op uw id-voordeelkaart (TTY: 711).                                                                                      |
| unD             | ဟံသာဝတီ- နမူနာကတိာ ကညီကိရ် အသိ, နမူနာ ကိရ်တိမာစာတဖ်, လာတလာ်ဘျီလာ်စုသုန့်လီ. ကိးတိက နှ်ထွဲပုစူးကတိာဖိ ဝဲနီဂ်ိလာအအိဂ်ိလာနတိန့်ဘျူး ID ခးကုအလီ (TTY: 711) တက့.                                                                                                     |
| Gagana Sāmoa    | FA'AALIGA: Afai e te tautala Fa'aSamoa, o lo'o avanoa le fesoasoani mo le gagana mo oe, e leai se totogi. Telefoni atu i le Tautua mo le Lautele (Customer Care) i le numera o le telefoni o lo'o i lau pepa ID (TTY: 711).                                     |
| Kajin Majol     | LALE: Ne kwoj konono kajin Majol, komaron in bok jipan ko ilo kajin ne am ejelok wonaan. Kirlok ro rej bok eddo im ej walok ilo ID kaat in jiban eo am (TTY: 711).                                                                                              |
| Română          | ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică gratuite. Sunați la Relații Clienți la numărul de telefon de pe cardul dvs. de beneficii (TTY: 711).                                                                |
| Foosun Chuuk    | MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei áninisin chiakku, ese kamo. Kopwe kokkori nampan Ánisi Chon Fiti won epekin om we taropwen esisinnan chon fiti. (TTY: 711).                                                |
| Tonga           | TOKANGA'I MAI: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'e totongi, pea teke lava 'o ma'u ia. Telefoni mai 'i he numera 'i he funga 'o ho'o kaati ID 'aonga (TTY: 711).                                           |
| Bisaya          | ATENSYON: Kung Cebuano imong sinultihan, adunay libreng serbisyo tabang sa lingguwahe nga imong magamit. Tawagi ang Customer Care ang numero ana-a sa imong benepisyong ID kard. (TTY: 711).                                                                    |
| Ikirundi        | ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona Serivisi y'Ubudandaji kuri izi numero za terefone ku nyungu za karangamuntu yawe (TTY: 711).                                                                     |
| Kiswahili       | KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata huduma za lughabila malipo. Piga simu kwenye Kituo cha Huduma kwa Wateja kupitia nambari ya simu iliyo nyuma ya kadi yako ya kitambulisho cha kupata manufaa (TTY: 711).                                   |

|                     |                                                                                                                                                                                                                                                                             |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bahasa Indonesia    | PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi Layanan Pelanggan di nomor telepon yang tertera pada kartu ID manfaat Anda (TTY: 711).                                                                   |
| Türkçe              | DİKKAT: Eğer Türkce konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. Sosyal Yardım Kimlik kartınızdaki telefon numarasından Müşteri Hizmetlerini arayın (TTY: 711).                                                                        |
| ಕುರ್ದಿ              | . ئاگاداری :ئەگەر بە زمانی کوردی قهسه ده کهیت، خزمهتگوزار به کانێ یارمهتی زمان، به‌خۆ. لای . تۆ<br>به‌رده‌سته. په‌یهوهندی به چاویدی به کار بکه له رێکهای ژمارهی سهر ناسنامه‌ي سوودت (TTY: 711)                                                                              |
| తెలుగు              | శ్రద్ధ పడండి: ఒకవేళ మీరు తెలుగుభాష మాట్లాడుకోవాల్సి ఉంటుంది అప్పుడు సహాయక సౌచికులను సంప్రదించండి. మన బసంపర్టు ఐడి కార్డులో పై ఉన్న నంబరు వద్ద<br>(TTY: 711) కస్టమర్ క్షర్వు కూల్ చేయండో                                                                                     |
| Thuwŋjaŋ            | PID KENE: Na ye jam nē Thuwŋjān, ke kuony yenē kɔc waar thok atō kuka lëu yök abac ke cîn wênh cuatê piny. Cəl răn tön dē kɔc kê luai ye kɔc kuony nē akuën दें tō nē I.D Kat du yic (TTY: 711).                                                                            |
| Norsk               | MERK: Hvis du snakker norsk er gratis språkhjelptjenester tilgjengelige for deg. Ring kundeservice på telefonnummeret som står på fordels-ID-kortet (TTY: 711).                                                                                                             |
| Català              | ATENCIÓ: Si parreu català, teniu disponible un servei d'ajuda lingüística sense cap càrrec. Truqueu a Atenció al client al número de telèfon que apareix en la vostra targeta d’identificació de beneficis (TTY: 711).                                                      |
| Ελληνικά            | Προσοχή: Εάν μιλάτε Ελληνικά, υπάρχει δωρεάν διαθέσιμη υπηρεσία γλωσσικής υποστήριξης.<br>Καλέστε το Κέντρο Υποστήριξης Πελατών στο τηλέφωνο που αναγράφεται στην Κάρτα σας προνομίων μέλους (TTY: 711).                                                                    |
| Igbo asusu          | NRUBAMA: O buru na i na asu Ibo, oru enyemaka asusu, bu n'efu, dijiri gi. Kroo Onye Ntuziaka na nombadi na kaadi NJ elele gi (TTY: 711).                                                                                                                                    |
| èdè Yorùbá          | Akiyesi: Bí o bá nsò èdè Yoruba, işe iranlọwó nípa èdè, láí sanwó, wà fún ọ̀. Pe Olutójú Oníbàará lóri nómbà ẹ̀ro ibánísọ̀rò ori káàdi idánimọ́ aláńfàani re (TTY: 711).                                                                                                    |
| Lokaiahn Pohnpei    | Ni songen mwohmw ohte, komw pahñ sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Ma komw anahne sawas ah komw kak call nembe me mih ni sapwelwmomi Benefit ID card. (TTY: 711). |
| Deutsch             | Wann du Deutsch schwetzschst, kannst du mitaus Koschte ebber gricke, ass dihr helfft mit die Englisch Schprooch. Ruf selli Nummer uff: Ruf die Leit bei Customer Care uff unnich die Nambr as uff dei Benefit-ID-Card is. (TTY: 711).                                       |
| 'Ōlelo Hawai'i      | E kaulona mai: Inā ‘ōlelo Hawai‘i ‘oe, aia ho‘i nā lawelawe ‘ōlelo, manawale‘a ho‘i kāia no ‘oe. Kelepona mai i ka helu i luna o kāu pepa ola no ke kūkua ia ‘oe (TTY: 711).                                                                                                |
| Adamawa             | MAANDO: To a waawii Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddir hakkilanoobe limngal gonngal dow kaatiwol ID maada (TTY: 711).                                                                                                                            |
| tsalagi gawonihisdi | ᑭᓄᓇ ᖃᗈᕿᑐᒃ: ᑦᑱᚵᙳᘉᑯ (GWY), ᓴᗈᕿᛁᑐᒃ ᑎᑏᓂᓂᓴᒃ ᑥᑦᑲᑏᓴᒃ, D49 Aᑦᓂᓴ ᑫᑦᑭᑦᑰᓴ ᓂᙳ Rᑦᑬᑦᑎᓴᓂᓴᑏᑦ. ᑎᑦᑶᓂᙳ ᑫᑦᑫᓴᓂᓴᒃ ᑎᑦᑡᑎᓮᓸᑦ ᑫᓂᙳ ᓴᓴᓂᓴ hᓴAᑫP ID DTᕿᑎᓂᓴ GVP &L (TTY: 711).                                                                                                                             |
| I linguahén Chamoru | ATENSIÓN: Yanggen un tunggo' I fino' Chamorro, i setbision lengguahi gaige para hagu dibatde ha. Agang i Ayudan Taotao gi numero gaige gi benefisiun ID kart-mu (TTY: 711).                                                                                                 |
| አማርኛ                | መረቅያ: እንደ አማርኛ ባለው መሆኑም ይህ የልማት ኢንተርኔት በስልክ (የፊደል) ቀጠላ በቀጠላ በሚሰጠው አገልግሎት (TTY: 711)(180.673.54AA)                                                                                                                                                                           |
| တြာနျူက             | သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊<br>အခွဲ၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ သင့် အကျိုးပြုအိုင်ဒါကို ဖုန်းနံပါတ်<br>(TTY: 711)ဖြင့် ဖောက်သည်ဂျပူကို ဖုန်းခေါ်ပါ။                                                                           |
| Diné Bizaad         | Díí baa akoʼ ninízindoo. Diné Bizaad bee ya nílti go, tʼáá jii kʼeh ná hólor, saad bee níká aʼ ályeedigít. Kojíʼ hó díł niih. (TTY: 711).                                                                                                                                   |
| Bàsók-wùdùn-po-nyò  | Dè dùǹ dyi nòmò dyín cáo: Ƨ jú ké òm̩ dyì Bàsók-wùdùn-po-nyò jú ní, níí, à wudu kà kò dò po-pòò béin òm̩ gbò kpáá. Sébéł nsingá í Téda Nsóm̩b í yé ntílgbaga í kat yòn yènè (TTY: 711).                                                                                     |
| Chahta              | ANUMPA PA PISAH: Chahta illa ish anumputi hokma, kvna kia Na Anumpa ya peh pillä hø chī toshola hinlä. Chi na halbena holisso iskitini mā holhtena yvt takanli mak ō itatoba ahalaia ya ī paya. (TTY: 711).                                                                 |
| Somali              | DIGNIIN: Haddii aad ku hadasho Soomaali, adeegyada taageerada luqadda, oo bilaash ah, ayaad geli kartaa. Ka wac Daryeelka Macmiilka lambarka ku yaalla kaarkaaga aqoonsiga ee dheeftaada (TTY: 711).                                                                        |