UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): UAW Retiree Medical Benefits Trust
Group Number: 12600
H2001-830
Section 1 – Introduction to Summary of Benefits

Your Health Care Coverage

This plan is offered through your Plan Sponsor.

You may be able to join or leave a plan only at certain times designated by your Plan Sponsor. If you choose to enroll in a Medicare health plan or Medicare Prescription Drug plan that is not offered by your Plan Sponsor, you may lose the option to enroll in a plan offered by your Plan Sponsor in the future. You could also lose coverage for other Plan Sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your Plan Sponsor’s open enrollment period, re-enrollment in any plan your Plan Sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your Plan Sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other benefits before submitting a request to enroll in a plan not offered by your Plan Sponsor, or a request to end your membership in our plan.

For more information please call UnitedHealthcare® Group Medicare Advantage (PPO) at the number listed below.

If you want information about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About UnitedHealthcare® Group Medicare Advantage (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-877-776-1469.

Things to Know About UnitedHealthcare® Group Medicare Advantage (PPO)

Hours of Operation

You can call us 8 a.m. to 8 p.m. local time, Monday - Friday

UnitedHealthcare® Group Medicare Advantage (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-866-480-0073.
- If you are not a member of this plan, call toll-free 1-877-776-1469.
- Our website: www.UHCRetiree.com/uawtrust
Who can join?

To join UnitedHealthcare® Group Medicare Advantage (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

Which doctors, and hospitals can I use?

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, and other providers. You can see any provider (in-network or out-of-network) that participates in Medicare at no additional cost to you. Your copays or coinsurance will be the same.

You can see our plan’s provider directory at our website www.UHCRetiree.com/uawtrust. Or, call us and we will send you a copy of the provider directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get all of the benefits covered by Original Medicare.** For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

UnitedHealthcare® Group Medicare Advantage (PPO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.
## Section 2 - Summary of Benefits

If you have any questions about this plan’s benefits or costs, please contact UnitedHealthcare for details.

<table>
<thead>
<tr>
<th>Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How much is the monthly premium?</strong></td>
</tr>
<tr>
<td>Contact your group plan benefit administrator to determine your actual premium amount, if applicable.</td>
</tr>
<tr>
<td><strong>How much is the deductible?</strong></td>
</tr>
<tr>
<td>This plan has deductibles for some hospital and medical services.</td>
</tr>
<tr>
<td>$245 per year for some in-network services.</td>
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<tr>
<td>$490 per year for some out-of-network services.</td>
</tr>
<tr>
<td>Your in-network deductible applies towards your out-of-network deductible and your out-of-network deductible applies towards your in-network deductible. You will never have to pay more than $490 as a total combined deductible for in and out-of-network services.</td>
</tr>
<tr>
<td><strong>Is there any limit on how much I will pay for my covered services?</strong></td>
</tr>
<tr>
<td>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan:</td>
</tr>
<tr>
<td>• $630 for services you receive from in-network providers for the following benefits:</td>
</tr>
<tr>
<td>o Inpatient Hospital Care</td>
</tr>
<tr>
<td>o Inpatient Mental Health in a Psychiatric Hospital</td>
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<tr>
<td>o Skilled Nursing Facility Care</td>
</tr>
<tr>
<td>o Outpatient Surgery</td>
</tr>
<tr>
<td>o Outpatient Hospital Services</td>
</tr>
<tr>
<td>o Partial Hospitalization</td>
</tr>
<tr>
<td>o Comprehensive Outpatient Rehabilitation Facility (CORF)</td>
</tr>
<tr>
<td>o Occupational Therapy</td>
</tr>
<tr>
<td>o Physical Therapy and Speech/Language Therapy</td>
</tr>
<tr>
<td>o Cardiac/Pulmonary Rehabilitation Services</td>
</tr>
<tr>
<td>o Kidney Dialysis</td>
</tr>
<tr>
<td>o Ambulance Services</td>
</tr>
<tr>
<td>o Part B Drugs</td>
</tr>
<tr>
<td>o Durable Medical Equipment</td>
</tr>
<tr>
<td>o Orthotics and Prosthetics</td>
</tr>
<tr>
<td>o Medical Supplies</td>
</tr>
<tr>
<td>o Diabetes Monitoring Supplies</td>
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<tr>
<td>o Medical Supplies</td>
</tr>
<tr>
<td>o Diagnostic Procedure/Test</td>
</tr>
<tr>
<td>o Clinical Laboratory Services</td>
</tr>
<tr>
<td>o Outpatient X-ray Services</td>
</tr>
<tr>
<td>o Diagnostic Radiology Services</td>
</tr>
<tr>
<td>o Therapeutic Radiology Service</td>
</tr>
<tr>
<td>• $1,500 for services you receive from in-network providers for the following benefits:</td>
</tr>
<tr>
<td>o Primary Care Physician Office Visit</td>
</tr>
</tbody>
</table>
○ Specialist Office Visit
○ Outpatient Mental Health/Substance Abuse
○ Chiropractic Visit (Medicare-covered)
○ Podiatry Visit (Medicare-covered)
○ Eye Exam (Medicare-covered)
○ Hearing Exam (Medicare-covered)
○ Dental Services (Medicare-covered)
○ Smoking Cessation Visit (Medicare-covered)
○ Emergency Room (includes Worldwide Coverage)
○ Urgently Needed Care (includes Worldwide Coverage)
○ Blood
○ Home Health Services
○ Hospice (Medicare-covered)
○ Cardiovascular Screenings (Medicare-covered)
○ Immunizations (Medicare-covered)
○ Pap Smears and Pelvic Exams (Medicare-covered)
○ Prostate Cancer Screening (Medicare-covered)
○ Colorectal Cancer Screenings (Medicare-covered)
○ Bone Mass Measurements (Medicare-covered)
○ Mammography (Medicare-covered)
○ Diabetes - Self Management Training (Medicare-covered)
○ Medical Nutrition Therapy and Counseling (Medicare-covered)
○ Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam. (Medicare-covered)
○ Annual Routine Physical Exam (Non Medicare-covered)
○ Routine Hearing Exam (Non Medicare-covered)
○ Routine Eye Exam (refraction)

● $1,395 for services you receive from out-of-network providers for the following benefits:
○ Inpatient Hospital Care
○ Inpatient Mental Health in a Psychiatric Hospital
○ Skilled Nursing Facility Care
○ Outpatient Surgery
○ Outpatient Hospital Services
○ Partial Hospitalization
○ Comprehensive Outpatient Rehabilitation Facility (CORF)
○ Occupational Therapy
○ Physical Therapy and Speech/Language Therapy
○ Cardiac/Pulmonary Rehabilitation Services
○ Kidney Dialysis
○ Ambulance Services
○ Part B Drugs
○ Durable Medical Equipment
○ Orthotics and Prosthetics
○ Medical Supplies
○ Diabetes Monitoring Supplies
○ Diagnostic Procedure/Test
Clinical Laboratory Services
Outpatient X-ray Services
Diagnostic Radiology Services
Therapeutic Radiology Service

- $3,000 for services you receive from out-of-network providers for the following benefits:
  Primary Care Physician Office Visit
  Specialist Office Visit
  Outpatient Mental Health/Substance Abuse
  Chiropractic Visit (Medicare-covered)
  Podiatry Visit (Medicare-covered)
  Eye Exam (Medicare-covered)
  Hearing Exam (Medicare-covered)
  Dental Services (Medicare-covered)
  Smoking Cessation Visit (Medicare-covered)
  Emergency Room (includes Worldwide Coverage)
  Urgently Needed Care (includes Worldwide Coverage)
  Blood
  Home Health Services
  Hospice (Medicare-covered)
  Cardiovascular Screenings (Medicare-covered)
  Immunizations (Medicare-covered)
  Pap Smears and Pelvic Exams (Medicare-covered)
  Prostate Cancer Screening (Medicare-covered)
  Colorectal Cancer Screenings (Medicare-covered)
  Bone Mass Measurements (Medicare-covered)
  Mammography (Medicare-covered)
  Diabetes - Self Management Training (Medicare-covered)
  Medical Nutrition Therapy and Counseling (Medicare-covered)
  Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam. (Medicare-covered)
  Annual Routine Physical Exam (Non Medicare-covered)
  Routine Hearing Exam (Non Medicare-covered)
  Routine Eye Exam (refraction)

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums.

<table>
<thead>
<tr>
<th><strong>Is there a limit on how much the plan will pay?</strong></th>
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<tbody>
<tr>
<td>No. There are no limits on how much our plan will pay.</td>
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<table>
<thead>
<tr>
<th><strong>Covered Medical and Hospital Benefits</strong></th>
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<table>
<thead>
<tr>
<th><strong>Outpatient Care and Services</strong></th>
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</thead>
</table>

<table>
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<tr>
<th><strong>Ambulance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- In-network: 10% of the cost</td>
</tr>
<tr>
<td>- Out-of-network: 10% of the cost</td>
</tr>
</tbody>
</table>
| **Chiropractic Care** | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):  
- In-network: $20 copay  
- Out-of-network: 50% of the cost |
|-----------------------|---------------------------------------------------------------------------------------------------------------|
| **Dental Services**   | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):  
- In-network: $25 copay  
- Out-of-network: 50% of the cost |
| **Diabetes Supplies and Services** | Diabetes monitoring supplies:  
- In-network: You pay nothing  
- Out-of-network: You pay nothing  
Diabetes self-management training:  
- In-network: You pay nothing  
- Out-of-network: You pay nothing  
Therapeutic shoes or inserts:  
- In-network: You pay nothing  
- Out-of-network: You pay nothing |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays** | Diagnostic radiology services (such as MRIs, CT scans):  
- In-network: 10% of the cost  
- Out-of-network: 30% of the cost  
Diagnostic tests and procedures:  
- In-network: 10% of the cost  
- Out-of-network: 30% of the cost  
Lab services:  
- In-network: You pay nothing  
- Out-of-network: You pay nothing  
Outpatient x-rays:  
- In-network: 10% of the cost  
- Out-of-network: 30% of the cost  
Therapeutic radiology services (such as radiation treatment for cancer):  
- In-network: 10% of the cost  
- Out-of-network: 30% of the cost |
| **Doctor’s Office Visits** | Primary care physician visit:  
- In-network: $20 copay  
- Out-of-network: 50% of the cost  
Specialist visit:  
- In-network: $25 copay  
- Out-of-network: 50% of the cost |
| **Durable Medical Equipment** (wheelchairs, oxygen, etc.) |  
- In-network: You pay nothing  
- Out-of-network: You pay nothing |
| Emergency Care | • $50 copay  
If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. |
|---|---|
| Foot Care | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:  
• In-network: $25 copay  
• Out-of-network: 50% of the cost  
**Additional benefit not covered by Original Medicare**  
Routine foot care (for up to 6 visits every year):  
• In-network: $25 copay for each visit  
• Out-of-network: 50% of the cost for each visit  
Benefit is combined in and out-of-network. |
| (podiatry services) |---|
| Hearing Services | Exam to diagnose and treat hearing and balance issues:  
• In-network: $25 copay  
• Out-of-network: 50% of the cost  
**Additional benefit not covered by Original Medicare**  
Routine hearing exam (for up to 1 every year):  
• In-network: You pay nothing for each visit  
• Out-of-network: 30% of the cost for each visit  
Benefit is combined in and out-of-network  
Hearing aids:  
• In-network: Plan pays up to a $2,000 allowance for two hearing aids every 3 years  
• Out-of-network: Plan pays up to a $2,000 allowance for two hearing aids every 3 years  
Benefit is combined in and out-of-network |
| Home Health Care | • In-network: You pay nothing  
• Out-of-network: You pay nothing |
| Mental Health Care | Inpatient visit:  
Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital.  
• In-network:  
  ○ 10% of the cost per stay, up to 190 days  
• Out-of-network:  
  ○ 30% of the cost per stay, up to 190 days  
Outpatient group therapy visit:  
• In-network: You pay nothing  
• Out-of-network: 50% of the cost  
Outpatient individual therapy visit:  
• In-network: You pay nothing |
<table>
<thead>
<tr>
<th>Service</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Rehabilitation</strong></td>
<td></td>
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<tr>
<td>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</td>
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<tr>
<td>Occupational therapy visit:</td>
<td>In-network: 10% of the cost</td>
<td>Out-of-network: 30% of the cost</td>
</tr>
<tr>
<td>Physical therapy and speech and language therapy visit:</td>
<td>In-network: 10% of the cost</td>
<td>Out-of-network: 30% of the cost</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group therapy visit:</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: 50% of the cost</td>
</tr>
<tr>
<td>Individual therapy visit:</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: 50% of the cost</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
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<tr>
<td>Ambulatory surgical center:</td>
<td>In-network: 10% of the cost</td>
<td>Out-of-network: 30% of the cost</td>
</tr>
<tr>
<td>Outpatient hospital:</td>
<td>In-network: 10% of the cost</td>
<td>Out-of-network: 30% of the cost</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong> (braces, artificial limbs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic devices:</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: You pay nothing</td>
</tr>
<tr>
<td>Related medical supplies:</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: You pay nothing</td>
</tr>
<tr>
<td><strong>Additional benefit not covered by Original Medicare</strong></td>
<td></td>
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</tr>
<tr>
<td>Wigs after Chemotherapy (for hair loss that is a result of Chemotherapy):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic devices:</td>
<td>In-network: Up to a $250 allowance for wigs/hairpieces (cranial prosthesis) every 12 months.</td>
<td>Out-of-network: Up to a $250 allowance for wigs/hairpieces (cranial prosthesis) every 12 months.</td>
</tr>
<tr>
<td>Related medical supplies:</td>
<td>In-network: You pay nothing</td>
<td>Out-of-network: You pay nothing</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong></td>
<td>In-network: 10% of the cost</td>
<td>Out-of-network: 10% of the cost</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$25 copay</td>
<td></td>
</tr>
</tbody>
</table>

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the “Inpatient Hospital Care” section of this booklet for other costs.
Vision Services

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):
- In-network: $0-$25 copay, depending on the service
- Out-of-network: 50% of the cost

Eyeglasses or contact lenses after cataract surgery:
- In-network: You pay nothing
- Out-of-network: You pay nothing

Additional benefit not covered by Original Medicare

Routine eye exam (for up to 1 every year):
- In-network: $25 copay
- Out-of-network: 50% of the cost
  Benefit is combined in and out-of-network.

Preventive Care

- In-network: You pay nothing
- Out-of-network: You pay nothing

Our plan covers many preventive services, including but not limited to:
- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
- “Welcome to Medicare” preventive visit (one-time)
- Yearly “Wellness” visit

Any additional preventive services approved by Medicare during the contract year will be covered.

Additional benefit not covered by Original Medicare

Fitness program:
$0 membership fee.

SilverSneakers® Fitness program through network fitness centers. There is no
visit or use fee for basic membership when you use network service providers. SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers fitness center. Member may select one of four kits that best fit their lifestyle and fitness level – general fitness, strength, walking or yoga.

**Additional benefit not covered by Original Medicare**

Nurseline℠:
You may call the Nurseline, 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.

<table>
<thead>
<tr>
<th><strong>Hospice</strong></th>
<th>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</th>
</tr>
</thead>
</table>

**Inpatient Care**

<table>
<thead>
<tr>
<th><strong>Inpatient Hospital Care</strong></th>
<th>Our plan covers an unlimited number of days for an inpatient hospital stay.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• In-network:</td>
</tr>
<tr>
<td></td>
<td>○ 10% of the cost per stay</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network:</td>
</tr>
<tr>
<td></td>
<td>○ 30% of the cost per stay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inpatient Mental Health Care</strong></th>
<th>For inpatient mental health care, see the “Mental Health Care” section of this booklet.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Skilled Nursing Facility (SNF)</strong></th>
<th>Our plan covers up to 100 days in a SNF.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• In-network:</td>
</tr>
<tr>
<td></td>
<td>○ 10% of the cost per day for days 1 through 100</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network:</td>
</tr>
<tr>
<td></td>
<td>○ 30% of the cost per day for days 1 through 100</td>
</tr>
</tbody>
</table>

**Prescription Drug Benefits**

<table>
<thead>
<tr>
<th><strong>How much do I pay?</strong></th>
<th>For Part B drugs such as chemotherapy drugs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• In-network: 10% of the cost</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network: 10% of the cost</td>
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<tr>
<td></td>
<td>Other Part B drugs:</td>
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<tr>
<td></td>
<td>• In-network: 10% of the cost</td>
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<tr>
<td></td>
<td>• Out-of-network: 10% of the cost</td>
</tr>
</tbody>
</table>

Our plan does not cover Part D prescription drugs.
Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-776-1469. Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-776-1469. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如需翻译服务，请致电1-877-776-1469。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-877-776-1469我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-776-1469. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d’interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d’assurance-médicaments. Pour accéder au service d’interprétation, il vous suffit de nous appeler au 1-877-776-1469. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-776-1469 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.


**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-776-1469번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-776-1469. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** لدينا خدمة الترجمة المجانية ل回答您关于我们的健康或药物计划的任何问题。要获取翻译服务，请拨打1-877-776-1469。会说英语的人士可以帮助您。这是一项免费服务。
Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-776-1469. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Disponemos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-776-1469. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-776-1469. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne korzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-776-1469. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके कस्तिं भी पुरश्चन के जवाब देने के लिए हमारे पास मुफ्त दुआपथिया सेवाएं उपलब्ध हैं। एक दुआपथिया पुरापुर्ल करने के लिए, बस हमें 1-877-776-1469 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-776-1469にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。
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