Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 844-373-2094. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 844-373-2094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of-Network: Individual \$2,000 / Family \$4,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Emergency care; In- <u>network</u> & out-of- network <u>prescription drugs</u> ; plus Tier 1 in- <u>network</u> & in- <u>network</u> office visits & <u>preventive</u> <u>care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductible</u> s for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$5,000 / Family \$10,000. Out-of-Network: Individual \$5,000 / Family \$10,000	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 844- 373-2094 for a list of Tier 1 in- <u>network</u> <u>providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1 in-network. You pay more if you use an in- network <u>provider</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	You need a <u>referral</u> from your PCP to see a <u>specialist</u> .

Coverage for: Individual + Family | Plan Type: POS

	What You Will Pay					
Common Medical Event	Services You May Need	MPHC Provider Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None	
lf you visit a health care <u>provider</u> 's	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None	
office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	30% <u>coinsurance</u>	You may have to pay for services tha aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
lf have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	30% coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	Not Applicable	20% coinsurance	30% <u>coinsurance</u>	None	
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/standard	Preferred generic drugs (Includes Tier 1A - Value Drugs and Tier 1 Preferred Generic Prescription Drugs)	Not applicable	<u>Copav</u> /prescription: Tier 1A 10% <u>coinsurance</u> up to maximum/prescripti on, <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order); Tier 1 20% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$20 (retail), \$40 (mail order)	<u>Copav</u> /prescription: Tier 1A 10% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$10 (retail); Tier 1 20% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$20 (retail)	Covers 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .	

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

Coverage for: Individual + Family | Plan Type: POS

	What You Will Pay				
Common Medical Event			In-Network Provider (You will pay	Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
	Preferred brand drugs	least) Not applicable	more) 30% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (mail order)	most) 30% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$50 (retail)	
	Non-preferred generic/brand drugs	Not applicable	50% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$100 (retail), \$200 (mail order)	50% <u>coinsurance</u> up to maximum/ prescription, <u>deductible</u> doesn't apply: \$100 (retail)	
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Emergency room care	\$300 <u>copay</u> /visits, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visits, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visits, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	\$250 <u>copay</u> /trip, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non- emergency transport: not covered, except 30% <u>coinsurance</u> if pre- authorized.
	<u>Urgent care</u>	Not applicable	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	MPHC Provider Tier 1 In-Network (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization required for out-of- network care
hospital stay	Physician/surgeon fees	Not applicable	20% <u>coinsurance</u>	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office & other outpatient services: \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Office: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
Services	Inpatient services	Not applicable	20% coinsurance	30% <u>coinsurance</u>	Pre-authorization required for out-of- network care
lf you are pregnant	Office visits	No charge; except \$20 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply	No charge; except \$40 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) Pre-authorization
	Childbirth/delivery professional services	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	required for out-of-network care may apply.
	Childbirth/delivery facility services	Not applicable	20% coinsurance	30% coinsurance	
	Home health care	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization required for out-of- network care
If you need help recovering or have	Rehabilitation services	Not applicable	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
other special health needs	Habilitation services	Not applicable	20% <u>coinsurance</u>	30% coinsurance	None
health needs	Skilled nursing care	Not applicable	20% <u>coinsurance</u>	30% <u>coinsurance</u>	150 days/calendar year. <u>Pre-</u> <u>authorization</u> required for out-of- network care

#### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA aetna

Coverage for: Individual + Family | Plan Type: POS

Common Medical Event	Services You May Need	MPHC Provider Tier 1 In-Network (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	Not applicable	20% coinsurance	30% coinsurance	Limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	Not applicable	0% <u>coinsurance</u>	30% <u>coinsurance</u>	Pre-authorization required for out-of- network care
f your child poods	Children's eye exam	No charge	No charge	No charge	1 routine eye exam/calendar year.
f your child needs lental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered.
icitial of cye care	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

#### **Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
<ul> <li>Cosmetic surgery</li> <li>Dental care (Adult &amp; Child)</li> <li>Glasses (Child)</li> </ul>	•	Long-term care Non-emergency care when traveling outside the U.S.	•	Routine foot care Weight loss programs - Except for required <u>preventive</u> <u>services</u> .

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul> <li>Acupuncture - 20 visits/calendar year for disease, injury &amp; chronic pain.</li> <li>Bariatric surgery - Limited to in-<u>network</u> <u>providers</u>.</li> <li>Chiropractic care - 40 visits/calendar year.</li> <li>Private-duty nursing</li> </ul>	t a r • F	Hearing aids - 80% after deductible, no limit to age 18, 2 hearing aids per 36 months, from age 18 \$3,000 per hearing aid every 36 months. Routine eye care (Adult) - 1 routine eye exam/calendar year.	•	Infertility treatment - \$10,000 lifetime limit per covered person. For more information & exceptions, see policy document provided by your employer or call the number on your ID card.	
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: ٠

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services aetna

#### MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

### Coverage for: Individual + Family | Plan Type: POS

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should . contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance • Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

About these Coverage Examples:



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

Dog is Having a Raby	
Peg is Having a Baby	
onthe of in notwork are notal care.	2

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$2,000
Specialist copayment	\$20
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$2,000
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,880

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

The plan's overall deductible	\$2,000
Specialist copayment	\$20
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
Deductibles	\$500
<u>Copayments</u>	\$1,100
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,630

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

The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist copayment	\$20
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

### This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800		
In this example, Mia would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$700		
<u>Coinsurance</u>	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$700		

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

#### Coverage for: Individual + Family | Plan Type: POS

#### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

#### **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

#### **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA

Coverage for: Individual + Family | Plan Type: POS

### TTY: 711

#### Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-382-1-
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ၚွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 <b>ကို ခေါ်ဆိုပါ။</b>
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	Յ֎ንԳ <del>Տ</del> ՕհA֎J Jh֎֍Ր֎ን ԹԵՐ (CWУ) ՉᲮWԾℹ <del>Տ</del> 1-888-982-3862 ℧℮ፐ Ը Aℾ֎J ժEGՐJ ℎԽℝՅ.
Chinese -	欲取得繁體中文語言協助,請撥打1-888-982-3862,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu  argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

	and Coverage: What this Plan Covers & What You Pay for Covered Services	Coverage Period: 01/01/2023-12/31/2023
<b>♥aetna</b> °	MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA	Coverage for: Individual + Family   Plan Type: POS
Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862.	Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, <sub>1-888-982-3862</sub> पर मुफ्त कॉल करें।	
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.	
lbo -	Maka enyemaka asusu na Igbo kpọọ 1-888-982-3862 na akwughi ugwọ ọ bula	1
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayada	anyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862	
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。	
Karen -	လ၊ တၢိမၢစားတၢိဳကတိၤကျိဉ်အင်္ဂါ ကျိဉ် အန88-982-3862 လ၊ တအိုဉ်ဒီးတၢိဳလ၊ ၁၁ဘူဉ်လ၊ ၁စူးဘဉ်	
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으	로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašsɔɔ́-̀wùdุùùň wɛ̃ɛ, dá 1-888-982-3862	
Kurdish -	ای را هنمایی به زبان فارسی با شمار ه 3862-3862 به خور ایی پهیومندی بکهن.	بر
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍ	ບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862) वर फोन करा.	
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.	
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3	862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ <b>ទទ</b> ៅកាន់លខេ 1-888-982-3862 ដ <b>ោយឥតគិតថ្</b> ព	งไป
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-	-888-982-3862
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि  1-888-982-3862 मा फोन गर्नुहोस् ।	
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aγöc.	
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.	
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।	
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.	
Persian - Polish -	بان فارسی با شمار ه 2-386-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.	برای راهنمایی به زی

· · ·	and Coverage: What this Plan Covers & What You Pay for Covered Services MARTIN'S POINT HEALTH CARE, INC. : QPOS® - POS with HRA	Coverage Period: 01/01/2023-12/31/2023
♥aetna®		overage for: Individual + Family   Plan Type: POS
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.	
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862	
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному в	юмеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma s	e totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.	
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.	
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-9	82-3862. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.	
Syriac -	הב שביה הי א הביוו מאור שלב ה ממואיה הה לי א א הביה אמר לא iser א ישבו א מאר שלב	1-888-982-3862
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.	
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)	
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใ	ใช้ล่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā	ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapv	v kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.	
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкошто	вним номером 1-888-982-3862.
Urdu -	مت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-386 ۔ پر بات کریں۔	بلاقي
Vietnamese -	Đề được hố trợ ngôn ngữ băng (ngôn ngữ), hãy gọi miến phi đến sốt-t	888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.	
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.	