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, call 1-866-633-2446 or visit welcometouhc.com. 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 www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: <strong>$750</strong> Individual / <strong>$2,250</strong> Family Out-of-Network: <strong>$750</strong> Individual / <strong>$2,250</strong> Family Per calendar year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: <strong>$3,000</strong> Individual / <strong>$9,000</strong> Family Out-of-Network: <strong>$3,000</strong> Individual / <strong>$9,000</strong> Family Per calendar year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover and penalties for failure to obtain preauthorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-633-2446 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>50% coinsurance</td>
<td>Virtual Visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>50% coinsurance</td>
<td>If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No Charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No coverage out-of-network.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab Testing: 0% coinsurance X-Ray/Diagnostics: No Charge</td>
<td>Lab Testing: Not covered X-Ray/Diagnostics: 50% coinsurance</td>
<td>Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. No coverage out-of-network for lab testing.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance, deductible does not apply</td>
<td>50% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition**                             | Tier 1 - Your Lowest Cost Option         | **Network Provider (You will pay the least)**                                     | Provider means pharmacy for purposes of this section.  
Retail: $10 copay, deductible does not apply.  
Mail-Order: $25 copay, deductible does not apply.  
**Out-of-Network Provider (You will pay the most)**                               | Retail: $10 copay, deductible does not apply. |
|                                                                                     | Tier 2 - Your Mid-Range Cost Option      | Retail: $30 copay, deductible does not apply.  
Mail-Order: $75 copay, deductible does not apply. |                                                                                       |
|                                                                                     | Tier 3 - Your Mid-Range Cost Option      | Retail: $60 copay, deductible does not apply.  
Mail-Order: $150 copay, deductible does not apply. |                                                                                       |
|                                                                                     | Tier 4 - Your Highest Cost Option        | Retail: 30% coinsurance  
Mail-Order: 30% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
| **If you have outpatient surgery**                                                  | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount. |
|                                                                                     | Physician/surgeon fees                   | 10% coinsurance | 50% coinsurance | None |

* For more information about limitations and exceptions, see the plan or policy document at [welcometouhc.com](http://welcometouhc.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$200 copay per visit then 10% coinsurance</td>
<td>*Network deductible applies.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>*Network deductible applies.</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>Virtual Visits - No Charge by a Designated Virtual Network Provider. No virtual coverage out-of-network. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 copay per visit, deductible does not apply</td>
<td>Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance, deductible does not apply. See your policy or plan document for additional information about EAP benefits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>No Charge</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20 copay per visit, deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
<td>Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| • Bariatric surgery  
• Cosmetic Surgery  
• Dental Care  
• Glasses  
• Infertility Treatment  
• Long Term Care  
• Non-emergency care when traveling outside - the US  
• Private duty nursing  
• Routine Eye Care  
• Routine foot care - Except as covered for Diabetes  
• Weight loss programs |

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
</table>
| • Acupuncture - 12 visits per calendar year  
• Chiropractic (manipulative) care - 25 visits per calendar year  
• Hearing aids - $5,000 per calendar year |

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Washington Office of the Insurance Commissioner at 1-800-562-6900 or insurance.wa.gov.

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 the 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.

Language Access Services:


Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne’ 1-866-633-2446.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.
**About these Coverage Examples:**

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. 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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $750
- **Specialist copay**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Specialist office visits (pre-natal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

The total Peg would pay is **$1,720**

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $750
- **Specialist copay**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

The total Joe would pay is **$700**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

- **The plan’s overall deductible**: $750
- **Specialist copay**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

The total Mia would pay is **$1,150**

The plan would be responsible for the other costs of these EXAMPLE covered services.
We do 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 number listed within this Summary of Benefits and Coverage (SBC), 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](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
**Complaint forms are available at** [http://www.hhs.gov/ocr/office/file/index.html](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 number contained within this Summary of Benefits and Coverage (SBC), TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

**ATENCIÓN:** Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。**

**XIN LUÚ Y:** 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 ghi trong bản Tóm lược về quyền lợi và đại thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.
알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagssasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng mga Benefisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чьи родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث العربية (Arabic) فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج داخل مخلص الميزارا والتحلية هنا (Summary of Benefits and Coverage, SBC).

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION: Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all’interno di questo Sommario dei Benefiti e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer 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。本「保障および給付の概要」（Summary of Benefits and Coverage, SBC）に記載されているフリー ダイヤルにてお電話ください。
้ายนี่: ยังดี อาป (Hindi) ไม่หายไป ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back. ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back.

CEEB TOOM: ยังดี อาป (Hindi) ไม่หายไป ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back. ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back.

PAKDAAR: ยังดี อาป (Hindi) ไม่หายไป ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back. ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back.

DÍÍ BAA'ÁKONÍNWÍN: Diné (Navajo) ยังดี อาป (Hindi) ไม่หายไป ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back. ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back.

OGOW: ยังดี อาป (Hindi) ไม่หายไป ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back. ฉันขอให้คุณต้องการให้ back และไม่ต้องการให้ back.