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, visit www.welcometouhc.com or by calling 1-866-673-6293. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,800 Individual / $3,200 Family out-of-Network: $5,600 Individual / $6,400 Family Per calendar year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, Office visits, Children's eye exams, and Children's dental check-up are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $8,000 Individual / $16,000 Family out-of-Network: $16,000 Individual / $32,000 Family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance	50% coinsurance	None
	Specialist visit	40% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	Not Covered	No coverage out-of-Network. Includes preventive health services specified in the health care reform law. 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.
If you have a test	Diagnostic test (x-ray, blood work)	Free Standing/Office: 40% coinsurance Hospital: 50% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit. Out-of-Network lab is not covered.
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 40% coinsurance Hospital: 50% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/rxfind	Tier 1 - Your Lowest-Cost Option	Retail: $20 copay Mail-Order: $50 copay Specialty Drugs: $20 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may not be covered until prior authorization is obtained. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. All medically necessary outpatient drugs are covered. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied, unless the higher tier drug is medically necessary. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: $85 copay Mail-Order: $212.50 copay Specialty Drugs: $150 copay	Not Covered	
	Tier 3 - Your Midrange-Cost Option	Retail: $135 copay Mail-Order: $337.50 copay Specialty Drugs: $250 copay	Not Covered	
	Tier 4 - Additional High-Cost Options	Retail: 25% coinsurance up to $250 copay per script. Mail-Order: 25% coinsurance up to $625 copay per script. Specialty Drugs: 25% coinsurance up to $250 copay per script.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surg Center: 40% coinsurance Hospital: 50% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per surgery. Out-of-Network Benefits, allowed amounts for Facility Fees is limited to $760 per date of service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	40% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	$300 Emergency per occurrence Copayment applies prior to the overall deductible.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	40% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Preauthorization required for out-of-Network (excluding Emergency admissions) or you will incur a penalty of $1,000 per admission. $250 Inpatient Stay per occurrence Copayment applies prior to the overall deductible.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visits: 40% coinsurance . All other outpatient Treatment: 40% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit.
	Inpatient services	40% coinsurance	50% coinsurance	Preauthorization required for out-of-Network (excluding Emergency admissions) or you will incur a penalty of $1,000 per admission.
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for prenatal care and office visits. One post-natal office visit is covered at No Charge. Additional postnatal visits - subject to primary care or specialist office visit copay depending on the type of provider.
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	Preauthorization required for out-of-Network inpatient stays over 48 hours following a normal vaginal delivery, or over 96 hours following a cesarean section delivery or you will incur a penalty of $1,000 per admission. $250 Inpatient Stay per occurrence Copayment applies prior to the overall deductible.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Limited to 100 visits per year. (counting all home health care visits other than for rehabilitative or habilitative care). Limited to 100 visits per calendar year for habilitative care. Limited to 100 visits per calendar year for rehabilitative care. Out-of-Network Benefits, allowed amounts for Home health care are limited to $150 per visit. Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit.
	Rehabilitation services	40% coinsurance	50% coinsurance	Manipulative Treatments are limited to 24 visits per year. Out-of-Network Benefits, are not available for Physical therapy, Occupational therapy, and Manipulative Treatments
	Habilitation services	40% coinsurance	50% coinsurance	Manipulative Treatments are limited to 24 visits per year. Out-of-Network Benefits, are not available for Physical therapy, Occupational therapy, and Manipulative Treatments Preauthorization required for out-of-Network before admission or you will incur a penalty of $1,000 per visit.
	Skilled nursing care	40% coinsurance	50% coinsurance	Skilled Nursing is limited to 100 days per benefit period. Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit.
	Durable medical equipment (DME)	40% coinsurance	50% coinsurance	None
	Hospice services	40% coinsurance	50% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or you will incur a penalty of $1,000 per admission.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance	One exam per year.
	Children's glasses	40% coinsurance	50% coinsurance	One pair per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No Charge	50% coinsurance	Cleanings covered once every 6 months. Additional limitations may apply.

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.)				
• Cosmetic Surgery	• Dental Care (Adult)	• Infertility services	• Long-Term Care	• Non-emergency care when traveling outside the U.S
• Private Duty Nursing	• Routine Foot Care	• Weight Loss Programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)				
• Acupuncture	• Bariatric surgery	• Chiropractic care - 24 visits per calendar year	• Hearing aids - 1 every 3 years; $2500 per calendar year	• Routine eye care (Adult) - 1 exam 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 are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov., or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. 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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.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 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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-6293 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293 .
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-673-6293 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-866-673-6293 .

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

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** **$ 2,800**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductible	$2,800
Copayments	$10
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,170**

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

- **The plan's overall deductible** **$ 2,800**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductible	$2,800
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,800**

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

- **The plan's overall deductible** **$ 2,800**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	
Deductible	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Notice of Non-Discrimination

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
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 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).

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 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 ghi trong bản Tóm lược về quyền lợi và đài 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 nagsasalita 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 Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (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. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

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 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 Benefit 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。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ **(Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ ដែលមានកត់នៅក្តង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការរ៉ាបរង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

UnitedHealthcare

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in your language, first call your insurance company's phone number at 1-800-842-2656.
Someone who speaks your language can help you. If you need more help, call the Department of Insurance Hotline at 1-800-927-4357.

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al 1-800-842-2656.
Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 1-800-927-4357. (Spanish)

中文

重要事項：您與您的醫生或醫療保險公司交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請先致電您的保險 公司，電話號碼 1-800-842-2656
說中文人士將為您提供協助。如需更多協助，請致電保險部熱線 1-800-927-4357(Chinese)

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.

PAUNAWA: 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 **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ़्री फ़ोन नंबर पर काल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer-Cambodian)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե **հայերեն (Armenian)** եք խոսում, անվճար լեզվական օգնության ծառայություններ են հասնում Ձեզ: Խնդրվում է զանգահարել անվճար հեռախոսահամարով, որը նշվել է Ձեր ճանաչողական քարտի վրա:

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ਼ ਰੀ ਨੰਬਰ 'ਤੇ ਕਾੱਲ ਕਰੋ।

โปรดทราบ: หากคุณพูด**ภาษาไทย (Thai)** มีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวของคุณ

Nondiscrimination Notice and Access to Communication Services

UnitedHealthcare does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by UnitedHealthcare directly or through a Network Medical Group or any other entity with which UnitedHealthcare arranges to carry out Covered Health Care Services under any of its Health Plans.

Free services are available to help you communicate with us such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your health plan ID card.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

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 health plan ID card, 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