## Important Questions

| What is the overall deductible? | Network: $6,300 Individual / $12,600 Family. Out-of-Network: $12,600 Individual / $25,200 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 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. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, First 3 visits for Primary care, Specialist, and Urgent care. Diagnostic test/Laboratory, Physicians fee for Emergency room, Outpatient Services for Behavioral Health, office visits, Rehabilitation, Habilitation, Hospice, Children’s eye exam, Glasses and Dental check-up | 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? | Yes, prescription drugs - $500 Individual/ $1000 Family. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Network: $8,200 Individual / $16,400 Family. Out-of-Network: $15,900 Individual / $31,800 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, 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 1-800-782-3740 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.

<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><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider (You will pay the least)</strong>: First 3 visits per year*: $65 copay per visit, deductible does not apply to the first three non-preventive visits combined. After 3 visits: 40% coinsurance</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% coinsurance</td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td>First 3 visits per year*: $95 copay per visit, deductible does not apply to the first three non-preventive visits combined. After 3 visits: 40% coinsurance</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% coinsurance</td>
<td>If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. * 3 visits include primary care, Specialist, and urgent care.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>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. No coverage out-of-Network.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Laboratory Tests: $40 copay per service, deductible does not apply X-Ray and Other Diagnostic Testing - Outpatient: 40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required for out-of-Network or you will incur a penalty of $1,000 per visit.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>--------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **If you need drugs to treat your illness or condition** | Tier 1 - Your Lowest-Cost Option | Retail: $18 copay  
Mail-Order: $45 copay | Not Covered |
|                     | Tier 2 - Your Midrange-Cost Option | Retail: 40% coinsurance up to $500 copay per script  
Mail-Order: 40% coinsurance up to $1250 copay per script | Not covered |
|                     | Tier 3 - Your Midrange-Cost Option | Retail: 40% coinsurance up to $500 copay per script  
Mail-Order: 40% coinsurance up to $1250 copay per script | Not Covered |
|                     | Tier 4 - Additional High-Cost Options | Retail: 40% coinsurance up to $500 copay per script  
Mail-Order: 40% coinsurance up to $1250 copay per script | Not covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% 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. |
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<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 you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>Facility fee: 40% coinsurance</td>
<td>Facility fee: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Facility fee: 40% coinsurance</td>
<td>Facility fee: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>First 3 visits per year*: $65 copay per visit, deductible does not apply</td>
<td>Facility fee: 40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Outpatient Office Visits: No Charge . All other outpatient Treatment: 0% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
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<td>Common Medical Event</td>
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</tr>
<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 you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$65 copay per outpatient visit, deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$65 copay per outpatient visit, deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment (DME)</td>
<td>40% coinsurance</td>
<td>Not covered</td>
</tr>
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<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>Hospice services</td>
<td>No Charge</td>
<td>50% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>50% coinsurance, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No Charge</td>
<td>50% coinsurance, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No Charge</td>
<td>10% coinsurance, deductible does not apply</td>
</tr>
</tbody>
</table>

**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
- 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 1-800-782-3740.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-782-3740.
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
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
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
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 LUU Y’: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngọn ngược miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đại thơ 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 ka ng 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 русским (Russian). Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

阿拉伯文: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج (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), udostępniamy 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 Benefici 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電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشد. لطفاً با شماره تلفن رایگان (Summary of Benefits and Coverage, SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निष्ठुल्क उपलब्धि हैं। साथी और करेज (Summary of Benefits and Coverage, SBC) के इस संरक्षण के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

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

ចងៀក្រមៀ៖ ប្រកបដោយសម្រាប់អាស៊ីកាល់ (Khmer) អាចទទួលបានសេវាកម្មជាតិដ៏សំខាន់ៗ និងសេវាកម្មទុកដាក់�លេខួតខ្លេន៍េ និងសេវាកម្មសេរីម៉ាស៊ីបម្រេង (Summary of Benefits and Coverage, SBC) ដ៏ល្អិត។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lenggwahe 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 yáníiti'go, saad bee áka'ánída'awó'ígíí, t'áá jít'eh, bee nááhóóít'i'. T'áá shqoñi Naaltsoos Bee 'Aa'áháyání dóó Bee 'Akl’éstii' Bee Baa Hane'íl (Summary of Benefits and Coverage, SBC) biyi' t'áá jít'ehgo béésh bee hane'í biká'íífí bee hodifílníih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan waq labarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefahaa iyo Caymiska (Summary of Benefits and Coverage, SBC).
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 LUÚ YÉ: Nêu quýt vĩ nói tiếng Viêt (Vietnamese), quýt vĩ sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau để hỏi viễn của quýt vĩ.

알림: 한국어(Korean)를 사용하시는 경우 어원 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 혜택번호로 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.

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

Farsi: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگان که روی کارت شناسایی شما قید شده تابنید.

हिंदी: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर दिए टोल-फ्री 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.

Khmer-Cambodian: ប្រយុទ្ធធប្រព័ន្ធផ្នែកសេវាដុំនឹងប្រកួតប្រជុំក្នុងហិរញ្ញវត្ថុនិងប្រកួតប្រជុំអ៊ីយតង់ៗ។

Armenian: Հիմնառույց (Armenian) երբեք հանում, սպասեք քաղաքական զբաղվություններ մեջ եւ գործում են։ Միջոցառումներ առաջաբեր մասնագիի, որոնց ներկա է եւ դառք փուլը։

Punjabi: تہلکہ: نے درمیانی ہندی (Punjabi) گھڑے رہے تے، یا تھا کہ ہندی ناں میں کے چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چوہ، چอ

โปรดทราบ: หากคุณพูดภาษาไทย (Thai) มีบริการความช่วยเหลือภาษาให้กับคุณโดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรที่เบอร์หมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวของคุณ
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**Mail:**
U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
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