UnitedHealthcare®

Benefit Summary

Core PPO Silver
California - Core
Core - Plan CBTI

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Core Plan?

Find network care nearby.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You have quality network care nearby. If you travel, you'll get access to a national network to help lower your costs.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/core** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$50	$2,250	20%

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> Your co-pays do not count towards meeting the deductible unless otherwise described within the specific covered health care service.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$2,250 per year	$4,500 per year
Medical Deductible - Family	$4,500 per year	$9,000 per year
Dental - Pediatric Services Deductible - Individual	You do not have to pay a dental deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	You do not have to pay a dental deductible.	Included in your medical deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$7,800 per year	$15,600 per year
Out-of-Pocket Limit - Family	$15,600 per year	$31,200 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	$50 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.
Ambulance Services		
	$250 co-pay per transport, after the medical deductible has been met.	$250 co-pay per transport, after the network medical deductible has been met.
Non-Emergency Ambulance:	$250 co-pay per transport, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for Non-Emergency Ambulance.	Prior Authorization is required for Non-Emergency Ambulance.
Breast Cancer Services		
	The amount you pay is based on where the covered health care service is provided.	
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Out-of-Network Benefits are not available.
	Prior Authorization is required.	
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	Out-of-Network Benefits are not available.
Dental Anesthesia		
Limited to Covered Persons who are one of the following: A child under seven years of age; a person who is developmentally disabled, regardless of age. A person whose health is compromised and for whom general anesthesia is required, regardless of age.	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 time every 6 months.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Fluoride Treatments Limited to 1 time every 6 months.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Space Maintainers (Spacers) Limited to once per provider, per quadrant or arch per lifetime.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) Limited to 1 time per 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.
Intraoral Radiographs (X-ray) Limited to 1 series of films per 6 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing. A deductible does not apply.	10% co-insurance. A deductible does not apply.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months per quadrant per provider.	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as a single filling and limited to 1 per tooth per 12 months.	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Implant Procedures	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is required for orthodontic treatment.	Prior Authorization is required for orthodontic treatment.
Dental Services and Oral Surgery- Accident Only		
	50% co-insurance, after the medical deductible has been met.	50% co-insurance, after the network medical deductible has been met.
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care: For Self-Management and Training, cost sharing will not exceed the costs for Physician office visit.	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME that costs more than $1,000.
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	The amount you pay for diabetes equipment is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Schedule of Benefits.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Durable Medical Equipment (DME), Orthotics and Supplies		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for DME or orthotics that costs more than $1,000.
Emergency Health Care Services - Outpatient		
	$400 co-pay per visit for Facility Fee, after the medical deductible has been met. You pay nothing for Physician Fee. A deductible does not apply.	$400 co-pay per visit for Facility Fee, after the network medical deductible has been met. You pay nothing for Physician Fee. A deductible does not apply.
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Fertility Preservation for Iatrogenic Infertility		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided.	
Habilitative Services and Manipulative Treatment		
Inpatient:	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows:	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient services.
Home Health Care		
Limited to 100 visits per calendar year for visits other than rehabilitative or hatbilitative care. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For Out-of-Network benefits, Allowed Amounts are limited to $150 per visit.	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hospice Care		
	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient:	$40 co-pay per service. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	$85 co-pay per service. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.
Major Diagnostic and Imaging - Outpatient		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mastectomy Services		
	The amount you pay is based on where the covered health care service is provided.	
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$50 co-pay per visit. A deductible does not apply.	50% co-insurance. A deductible does not apply.
All Other Outpatient Treatment:	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Obesity - Weight Loss Surgery		
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Out-of-Network Benefits are not available.
Off-Label Drug Use and Experimental or Investigational Services		
	The amount you pay is based on where the covered health care service is provided.	
Osteoporosis Services		
	The amount you pay is based on where the covered health care service is provided.	
Ostomy and Urological Supplies		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home. Applies to drugs administered by a provider on an outpatient basis in a Hospital, Alternate Facility or Physician's office.	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Treatment		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Physician Fees for Surgical and Medical Services		
	20% co-insurance for outpatient. A deductible does not apply. 20% co-insurance for inpatient, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	$50 co-pay per visit for a primary care physician office visit. A deductible does not apply. $85 co-pay per visit for a specialist office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
We pay for Covered Health Care Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit	**Hospital - Inpatient Stay:** 20% co-insurance, after the medical deductible has been met. **Physician Fees for Surgical and Medical Services** 20% co-insurance, after the medical deductible has been met. **Prenatal Care and Preconception Physician Office Visit:** You pay nothing. A deductible does not apply. **First Postnatal/Postpartum Physician Office Visit:** You pay nothing. A deductible does not apply. **Subsequent Postnatal/Postpartum Physician Office Visit:** The amount you pay is based on where the covered health service is provided.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office and other Preventive Services.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prosthetic Devices		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
	$50 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available for physical therapy, occupational therapy, and Manipulative Treatment. 50% co-insurance for all other therapies, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)		
Limited to 100 days per benefit period for Skilled Nursing Facility.	20% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Specialized Footwear		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for specialized footwear that costs more than $1,000.
Surgery - Outpatient		
	20% co-insurance. A deductible does not apply.	For Out-of-Network Benefits, Allowed Amount for Facility Fees is limited to $760 per date of service. 50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth Services		
	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Urinary Catheters		
	20% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Virtual Visits		
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups. See Behavioral Health Supplement for telehealth services.	$50 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Exam Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/ or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Low Vision Care Services		
Low Vision Comprehensive Evaluation Limited to once every 24 months.	You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.	25% co-insurance for Low Vision Comprehensive Evaluation. A deductible does not apply.
Low Vision Follow-up Care Limited to four visits in any 5 year period.	You pay nothing for Low Vision Follow-up Care. A deductible does not apply.	25% co-insurance for Low Vision Follow-up Care. A deductible does not apply.
Low vision aid such as high-power spectacles, magnifiers and telescopes. Limited to once every 12 months.	You pay nothing for Low Vision aid such as high-power spectacles, magnifiers and telescopes. The medical deductible does not apply.	25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.
Vision Exams (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam per calendar year.	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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

For Internal Use only:

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UnitedHealthcare Benefits Plan of California does 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 Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare 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 ID card, 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 others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 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.

PAALALA: 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 **русском (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.

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 sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。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)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन 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 deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

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

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

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 ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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