










# EPO plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan		EPO
	<b>Network coverage only</b> You can usually save money when you receive care for covered health care services from network providers.	<input checked="" type="checkbox"/>
	<b>Network and out-of-network benefits</b> You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	<input type="checkbox"/>
	<b>Primary care physician (PCP) required</b> With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	<input type="checkbox"/>
	<b>Referrals required</b> You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	<input type="checkbox"/>
	<b>Preventive care covered at 100%</b> There is no additional cost to you for seeing a network provider for preventive care.	<input checked="" type="checkbox"/>
	<b>Pharmacy benefits</b> With this plan, you have coverage that helps pay for prescription drugs and medications.	<input checked="" type="checkbox"/>
	<b>Tier 1 providers</b> Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	<input type="checkbox"/>
	<b>Freestanding centers</b> You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	<input checked="" type="checkbox"/>
	<b>Health savings account (HSA)</b> With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	<input checked="" type="checkbox"/>

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. 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.

# Here's a more in-depth look at how EPO works

## Medical Benefits

	In Network
Annual Medical Deductible	
Single Coverage	\$3,000
Family Coverage	\$6,000
Ped Dental Annual Deductible - Family	Included in your medical deductible
Ped Dental Annual Deductible - Individual	Included in your medical deductible

No one in the family is eligible for benefits until the family coverage deductible is met.

*\*After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	\$7,150
Family	\$14,300

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services
Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network
Preventive Care Services	
Preventive Care Services	No copay
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 copay, coinsurance or deductible.	
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.	

\*After the Annual Medical Deductible has been met.  
 †Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

#### Office Services - Sickness & Injury

Primary Care Physician

\$30 copay\*

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

*Telehealth is covered at the same cost share as in the office.*

Specialist

\$60 copay\*

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

*Telehealth is covered at the same cost share as in the office.*

Telemedicine Program (Virtual Visits)

No copay\*

*Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card.*

Urgent Care Center Services

\$100 copay\*

#### Emergency Care

Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)

Air Ambulance

20%\*

Ground Ambulance

20%\*

Emergency Department

\$500 copay\*

*There is no cost for health care forensic examinations performed under Public Health Law §2805-i.*

Non-Emergency Ambulance (Ground and Air Ambulance)

Air Ambulance

20%\*

Ground Ambulance

20%\*

\*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network
<b>Inpatient Care</b>	
Inpatient Habilitative Services (Physical, Speech & Occupational Therapy)	20%*
<i>Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.</i>	
Inpatient Hospital for a Continuous Confinement	20%*
Inpatient Medical Visits	20%*
Physician Fees for Surgical and Medical Services - Inpatient	20%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	20%*
<i>Limited to 60 days per year in an Inpatient Rehabilitation Facility.</i>	
<i>The limit for Inpatient Rehabilitation Services applies to any combination of physical therapy, occupational therapy, and speech therapy.</i>	
<b>Outpatient Care</b>	
Chiropractic Services	\$60 copay*
Habilitative Services - Outpatient	\$60 copay*
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>	
<i>Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.</i>	
Home Health Care	\$60 copay*
<i>Limited to 40 visits per year.</i>	
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Home infusion counts toward home health care visit limits.</i>	
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing	
Performed as Outpatient Hospital Services	20%*
Performed in a Freestanding Radiology Facility	20%*
Performed in a PCP Office	\$30 copay*
Performed in a Specialist Office	\$60 copay*

\*After the Annual Medical Deductible has been met.

\*Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing

Performed as Outpatient Hospital Services	\$90 copay*
Performed in a Freestanding Radiology Facility	\$90 copay*
Performed in a PCP Office	\$30 copay*
Performed in a Specialist Office	\$60 copay*

Major Diagnostic and Imaging - Outpatient

Performed as Outpatient Hospital Services	\$100 copay*
Performed in a Freestanding Radiology Facility	\$100 copay*
Performed in a Specialist Office	\$60 copay*

Physician Fees for Surgical and Medical Services - Outpatient

For services provided at an ambulatory surgical center or in a physician's office	20%*
For services provided at an outpatient hospital-based surgical center	20%*

Rehabilitation Services - Outpatient Therapy

\$60 copay\*

*Limited to 30 visits of post-cochlear implant aural therapy per year.*

*Limited to 60 combined visits of physical therapy, occupational therapy and speech therapy per year.*

Surgery - Outpatient

For services provided at an ambulatory surgical center or in a physician's office	\$250 copay*
For services provided at an outpatient hospital-based surgical center	\$250 copay*

\*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

#### Therapeutic Treatments - Outpatient

Performed as Outpatient Hospital Services	\$250 copay*
Performed in a Freestanding Radiology Facility	\$60 copay*
Performed in a PCP Office	\$30 copay*
Performed in a Specialist Office	\$60 copay*

*Out of Network: Limited to 10 visits per year for dialysis.*

*Dialysis is not covered out-of-network, except for up to 10 visits per calendar year from a non-network provider to be paid at the network level when approved in advance.*

#### Supplies and Services

Diabetic Education	\$30 copay*
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Diabetic Equipment, Supplies, Insulin and Diabetic Oral and Injectable Anti-Diabetic Agents	\$30 copay*
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*There is no cost in-network for insulin.*

Durable Medical Equipment and Braces	20%*
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External Hearing Aids	20%*
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*Limited to a single purchase per hearing impaired ear every 3 years.*

*Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*

#### Prescription Drugs Administered in Office or Outpatient Facilities

Performed in Outpatient Facilities	20%*
Performed in a PCP Office	\$30 copay*
Performed in a Specialist Office	\$60 copay*

*This includes medications given at a doctor's office, or in a covered person's home.*

\*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

#### Prosthetic Devices

External 20%\*

Internal 20%\*

*Limited to 1 prosthetic device per limb per lifetime.*

*Limit applies to External Prosthetic Devices only.*

*Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*

#### Pregnancy

##### Maternity and Newborn Care

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

*One Home Care visit is covered at no cost-sharing if mother is discharged from Hospital early.*

*There is no cost for network prenatal care and postnatal care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.*

#### Mental Health Care & Substance Related and Addictive Disorder Services

Inpatient Hospital or Residential Facility 20%\*

Intensive Behavioral Therapy (e.g. ABA Treatment for Autism Spectrum Disorder) No copay\*

Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment No copay\*

Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs provided in a Facility licensed, certified, or otherwise authorized by OMH No copay\*

*There is no cost for Network Opioid Treatment Programs, after deductible.*

Outpatient Office Visits \$60 copay\*

*There is no cost for Network Opioid Treatment Programs, after deductible.*

\*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network
<b>Other Services</b>	
Abortion Services	No copay*
Assistive Communication Devices for Autism Spectrum Disorder	\$30 copay*
Clinical Trials	The amount you pay is based on where the covered health care service is provided.
Hospice Care	
Inpatient	20%*
Outpatient	\$60 copay*
Infertility Services	The amount you pay is based on where the covered health care service is provided.
Medical Supplies	20%*
Obesity - Weight Loss Surgery	20%*
Oral Surgery	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.
Reconstructive Procedures	The amount you pay is based on where the covered health care service is provided.
Retail Health Care Clinic	\$30 copay*
Second and third Opinions	\$60 copay*
<p><i>If you obtain a second opinion for a diagnosis of cancer from an out-of-Network provider, it will be covered at the Network Benefit level.</i></p> <p><i>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist.</i></p> <p><i>There is no charge to you for second or third opinions requested by us.</i></p>	
Transplantation Services <sup>1</sup>	20%*
<p><i>Transplantation services must be received from a Designated Provider.</i></p>	
Wigs	20%*
<p><i>Limited to one wig per lifetime.</i></p>	

\*After the Annual Medical Deductible has been met.

<sup>1</sup>Prior Authorization Required. Refer to COC/SBN.



## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

#### Pediatric Services - Dental

All Pediatric Dental - Benefits covered up to age 19

*Additional limits may apply. Refer to your plan documents for more information.*

Basic Dental Services

20%\*

Diagnostic Services

No copay\*

*Limited to 1 time every 36 months for Panoramic x-rays.*

*Limited to 2 evaluations (checkup exams) every 12 months.*

*Limited to 2 series of films every 12 months of Bitewing x-rays.*

Major Restorative Services

50%\*

Medically Necessary Orthodontics<sup>1</sup>

50%\*

*All orthodontic treatment must be prior authorized.*

Preventive Services

No copay\*

*Limited to 2 dental prophylaxis cleanings and fluoride treatments every 12 months.*

#### Pediatric Services - Vision

All Pediatric Vision - Benefits Covered up to age 19

Contact Lenses/Necessary Contact Lenses

50%\*

*Limited to 1 fitting and evaluation every 12 months.*

*Limited to a 12 month supply.*

*We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*

\*After the Annual Medical Deductible has been met.

<sup>1</sup>Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

### Copays (\$) and Coinsurance (%) for Covered Health Care Services

#### Network

#### Eyeglass Frames

Eyeglass frames with a retail cost below \$130.	50%*
Eyeglass frames with a retail cost between \$130-\$160.	50%*
Eyeglass frames with a retail cost between \$160-\$200.	50%*
Eyeglass frames with a retail cost between \$200-\$250.	50%*
Eyeglass frames with a retail cost greater than \$250.	50%*

*Limited to once every 12 months.*

#### Eyeglass Lenses

50%\*

*Limited to once every 12 months.*

#### Lens Extras

No copay\*

*Limited to once every 12 months.*

*Coverage includes polycarbonate lenses and standard scratch-resistant coating.*

#### Routine Vision Exam

No copay

*Limited to once every 12 months.*

\*After the Annual Medical Deductible has been met.

\*Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Broad Rx Network
Prescription Drug List	Advantage
In Network	
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

Annual Deductible

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply	Up to a 90-day supply
	Retail and Specialty Pharmacy Network	In-Network Mail Order Pharmacy**
Tier 1 \$	\$10*	\$25*
Tier 2 \$\$	\$40*	\$100*
Tier 3 \$\$\$	\$80*	\$200*

\*\* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills. Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

# Here's an example of how the plan's costs come into play

## 1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

## 2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance**.\*

YOU PAY 20%\*

YOUR PLAN PAYS 80%

## 3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

\*Your coinsurance may vary by service. This example is for illustrative purposes only.

## Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

## Get connected

Scan this code to download the UnitedHealthcare app or visit [myuhc.com](https://myuhc.com)



# Other important information about your benefits

## Medical Exclusions

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.

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

## Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In-Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Retail Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy or Preferred 90 Day Retail Network Pharmacy.

# Other important information about your benefits

## Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an Appeal as described in the Utilization Review and External Appeal sections of the Certificate.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill, except for assistive communication devices.
- We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
- We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly 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](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608, Salt Lake City, UT 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, 1-800-537-7697 (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. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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

**توضيح:** (Arabic)،  
يوفر خدمات الترجمة  
لغة مجانية للأشخاص  
الذين يتحدثون اللغة  
الروسية. يرجى الاتصال  
بالرقم المجاني المذكور  
على بطاقة هويتك.

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

**ध्यान दें:** यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नशुलक 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.

**ΠΡΟΣΟΧΗ :** Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

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

**DÍI BAA'ÁKONÍNÍZIN:** Diné (**Navajo**) bizaad bee yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shq'odí ninaaltsoos nítł'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh 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.

**ગુજરાતી (Gujarati):** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વગરના મૂલ્યે પ્રાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.