



Southern California Drug Benefit Fund



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/uhcwest](http://www.welcometouhc.com/uhcwest) or by calling 1-800-624-8822. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-624-8822 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| What is the overall deductible?                             | \$300/individual or \$600/family.   | 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, primary care, specialist visits and testing services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                             |
| 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?              | For participating providers \$2,000 individual / \$4,000 family.<br>For prescription drugs from participating pharmacies: For the 2022 calendar year: \$6,550 individual / \$13,100 family; Effective 1/1/23, for the 2023 calendar year: \$6,700/individual / \$13,400/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?            | Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.  | 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 <a href="http://www.welcometouhc.com/uhcwest">www.welcometouhc.com/uhcwest</a> or call 1-800-624-8822 for a list of participating 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 a non-participating 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 participating provider might use a non-participating 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?                 | Yes, written or oral approval is required, based upon medical policies.   | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.  |



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   |
|--|--|--|---|--|
|  |  | Participating Provider<br>(You will pay the least)   | Non-Participating Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$35 <a href="#">copay</a> / office visit and \$25 <a href="#">copay</a> / Virtual visits by a designated virtual <a href="#">participating provider</a> ; <a href="#">deductible</a> does not apply | Not covered   | If you receive services in addition to office visit, additional <a href="#">copayments</a> , <a href="#">deductibles</a> or <a href="#">coinsurance</a> may apply.   |
|  | <a href="#">Specialist</a> visit                       | \$35 <a href="#">copay</a> / visit; <a href="#">deductible</a> does not apply  | Not covered   | Member is required to obtain a <a href="#">referral</a> to <a href="#">specialist</a> or other licensed health care practitioner, except for OB/GYN <a href="#">Physician services</a> , reproductive health care services within the <a href="#">Participating Medical Group</a> and Emergency / Urgently needed services. If you receive services in addition to office visit, additional <a href="#">copayments</a> , <a href="#">deductibles</a> or <a href="#">coinsurance</a> may apply. |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge; <a href="#">deductible</a> does not apply   | Not covered   | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge; <a href="#">deductible</a> does not apply   | Not covered   | None   |
|  | Imaging (CT/PET scans, MRIs)                           | No charge; <a href="#">deductible</a> does not apply   | Not covered   |  |

| Common Medical Event   | Services You May Need  | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|--|--|--|--|
|  |  | Participating Provider (You will pay the least)                    | Non-Participating Provider (You will pay the most) |  |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1-800-788-7871.</p> | Generic  | \$8 <u>copay</u> / prescription; <u>deductible</u> does not apply  | Not covered  | <p>You must use a Participating Pharmacy listed on the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. Limited to a 30-day supply (90-day supply for maintenance drugs in certain therapeutic classifications). If you purchase a brand drug when a generic drug is available, you pay the brand drug <u>copay</u> plus the difference in cost between the brand drug and the generic drug unless your <u>provider</u> indicates “dispense as written.” Mail order only available outside California. See the website listed or call 1-800-788-7871 for information on drugs covered by your <u>plan</u>. Not all drugs are covered.</p>  |
|  | <u>Formulary</u> brand drugs (Preferred)                             | \$25 <u>copay</u> / prescription; <u>deductible</u> does not apply | Not covered  |  |
|  | Non- <u>Formulary</u> brand drugs (Non-Preferred)                    | \$45 <u>copay</u> / prescription; <u>deductible</u> does not apply | Not covered  |  |
|  | <u>Preventive Care</u> Drugs (including FDA approved Contraceptives) | No charge; <u>deductible</u> does not apply                        | Not covered  | <p>You must use a Participating Pharmacy listed in the UFCW Participating Pharmacy Directory of the Southern California Drug Benefit Fund or no coverage. You must have a prescription or no coverage. Coverage is for generic drugs only (or brand name if a generic drug is unavailable or medically inappropriate). <u>Preventive Care</u> Drugs are limited to aspirin, fluoride supplementation, folic acid, colon cancer screening prep products, tobacco cessation medications, statin preventive medication, breast cancer preventive medication (e.g., Tamoxifene), FDA-approved female contraceptives, and pre-exposure prophylaxis (PrEP) for persons at increased risk of HIV acquisition. Age and frequency limits apply.</p> |
|  | <u>Injectable (Specialty) Drugs</u>                                  | 20% <u>coinsurance</u> ; <u>deductible</u> does not apply          | Not covered  | <p><u>Preauthorization</u> from Optum Rx is required or no coverage. Injectables prescribed by UHC physicians and provided by UHC are covered at 100% by UHC and are not covered under the <u>Prescription Drug Plan</u>. If injectable drugs are administered in a UHC physician’s office, office visit <u>Copayment/Coinsurance</u> may also apply.</p>  |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center)                       | 25% <u>coinsurance</u>   | Not covered  | None   |
|  | Physician/surgeon fees   | No charge; <u>deductible</u> does not apply                        | Not covered  |  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | Participating Provider<br>(You will pay the least)              | Non-Participating Provider<br>(You will pay the most)           |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 <u>copay</u> / visit;<br><u>deductible</u> does not apply | \$150 <u>copay</u> / visit;<br><u>deductible</u> does not apply | <u>Copayment</u> waived if admitted.  |
|   | <a href="#">Emergency medical transportation</a> | No charge;<br><u>deductible</u> does not apply                  | No charge;<br><u>deductible</u> does not apply                  | None  |
|   | <a href="#">Urgent care</a>                      | \$35 <u>copay</u> / visit;<br><u>deductible</u> does not apply  | \$75 <u>copay</u> / visit;<br><u>deductible</u> does not apply  | If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply.  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 25% <u>coinsurance</u>  | Not covered   | None  |
|   | Physician/surgeon fees                           | No charge;<br><u>deductible</u> does not apply                  | Not covered   |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$20 <u>copay</u> / visit;<br><u>deductible</u> does not apply  | Not covered   | Must use an HMC <u>provider</u> or no coverage. To find HMC <u>providers</u> , see <a href="http://hmc.personaladvantage.com">hmc.personaladvantage.com</a> (Access Code: SCDBF) or call 1-866-268-2510. <u>Preauthorization</u> from HMC is required for ECT, psychological testing and neuropsychological testing. Care may include tests and services described elsewhere in the SBC (i.e., <u>diagnostic test</u> ).                                  |
|   | Inpatient services                               | 20% <u>coinsurance</u>  | Not covered   | <u>Preauthorization</u> from HMC is required for all inpatient services, except emergency <u>hospitalization</u> . To find HMC <u>providers</u> , see <a href="http://hmc.personaladvantage.com">hmc.personaladvantage.com</a> (Access Code: SCDBF) or call 1-866-268-2510. Inpatient services include inpatient detox, inpatient rehabilitation, residential treatment programs, intensive outpatient programs, and partial day <u>hospitalization</u> . |
| If you are pregnant   | Office visits                                    | No charge;<br><u>deductible</u> does not apply                  | Not covered   | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).  |
|   | Childbirth/delivery professional services        | \$35 <u>copay</u> / visit;<br><u>deductible</u> does not apply  | Not covered   |   |
|   | Childbirth/delivery facility services            | 25% <u>coinsurance</u>  | Not covered   |   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|---|---|--|
|   |   | Participating Provider (You will pay the least)   | Non-Participating Provider (You will pay the most)                    |  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge; <u>deductible</u> does not apply   | Not covered   | Limited to 100 visits per calendar year.   |
|   | <a href="#">Rehabilitation services</a>   | \$35 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered   | Coverage is limited to physical, occupational, and speech therapy.   |
|   | <a href="#">Habilitative services</a>     | \$35 <u>copay</u> / visit; <u>deductible</u> does not apply   | Not covered   | Coverage is limited to physical, occupational, and speech therapy.   |
|   | <a href="#">Skilled nursing care</a>      | 25% <u>coinsurance</u>  | Not covered   | Up to 100 days per benefit period.   |
|   | <a href="#">Durable medical equipment</a> | No charge; <u>deductible</u> does not apply   | Not covered   | None   |
|   | <a href="#">Hospice services</a>          | No charge; <u>deductible</u> does not apply   | Not covered   | If inpatient admission, subject to inpatient <u>copayments</u> , <u>deductibles</u> or <u>coinsurance</u> .  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | UHC: No charge<br>Fund: No charge; <u>deductible</u> does not apply   | UHC: Not covered<br>Fund: No charge; <u>deductible</u> does not apply | UHC: None<br>Fund: Maximum benefit of \$135 per exam   |
|   | Children's glasses                        | UHC: Not covered<br>Fund: You pay all charges over the Fund's allowance; <u>deductible</u> does not apply.                              |   | Fund: <u>Allowed amount</u> of \$135 per year is reduced by the cost of the eye exam(s) paid by the Fund. Pediatric vision benefits are for children up to 19 years. Unused vision benefits from 2022 roll over for use in 2023. |
|   | Children's dental check-up                | UHC: Not covered<br>Fund: You may elect coverage from the Indemnity Dental <u>Plan</u> or the United Concordia Dental HMO <u>Plan</u> . |   | Your dental coverage is not subject to health care reform.   |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care</li> <li>Cosmetic surgery</li> </ul>  | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>                           | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care (Fund provides limited benefit of up to \$120 per calendar year)</li> </ul>   |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)  |   |  |
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Dental care (Adult) - (available under separate Indemnity Dental <u>Plan</u> or United Concordia Dental HMO)</li> </ul>         | <ul style="list-style-type: none"> <li>Hearing aids – (Benefit is provided separately through the Trust Fund. Maximum benefit of \$750 for each ear in a 12-month period).</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult) - (Coverage for glasses and contacts is limited to Fund provided benefit of \$135/year for exam, frame and Lenses).</li> <li>Weight loss programs</li> </ul> |

**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 9<sup>th</sup> Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://www.dmhc.ca.gov), or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://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](http://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 9<sup>th</sup> Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://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 the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-624-8822.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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 participating provider pre-natal care and a hospital delivery)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$35  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

|                                   |                |
|-----------------------------------|----------------|
| <i>Cost Sharing</i>               |                |
| <a href="#">Deductibles</a>       | \$300          |
| <a href="#">Copayments</a>        | \$40           |
| <a href="#">Coinsurance</a>       | \$1,700        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,100</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine participating provider care of a well-controlled condition)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$35  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

[Primary care physician](#) office visit (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

|                                   |              |
|-----------------------------------|--------------|
| <i>Cost Sharing</i>               |              |
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$900        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$900</b> |

### Mia's Simple Fracture

(participating provider emergency room visit and follow up care)

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$300 |
| ■ <a href="#">Specialist copayment</a>                          | \$35  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%   |
| ■ Other <a href="#">coinsurance</a>                             | 20%   |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

|                                   |              |
|-----------------------------------|--------------|
| <i>Cost Sharing</i>               |              |
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$400        |
| <a href="#">Coinsurance</a>       | \$40         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$440</b> |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-624-8822.

**English**

**IMPORTANT LANGUAGE INFORMATION:**

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. If you need more help, call DMHC Help Line at 1-888-466-2219.

**Spanish**

**INFORMACIÓN IMPORTANTE SOBRE IDIOMAS:**

Es probable que usted disponga de los derechos y servicios a continuación. Puede pedir un intérprete o servicios de traducción sin cargo. Es posible que tenga disponible documentación impresa en algunos idiomas sin cargo. Para recibir ayuda en su idioma, llame a su plan de salud de UnitedHealthcare of California al 1-800-624-8822 / TTY: 711. Si necesita más ayuda, llame a la Línea de Ayuda de la DMHC al 1-888-466-2219.

**Chinese**

**重要語言資訊：**

您可能有資格享有下列權利並取得下列服務。您可以免費獲取口譯員或翻譯服務。部分語言亦備有免費書面資訊。如欲以您的語言取得協助，請撥打下列電話與您的健保計畫聯絡：UnitedHealthcare of California 1-800-624-8822 / 聽力語言殘障服務專線 (TTY)：711。如果您需要更多協助，請撥打 DMHC 協助專線 1-888-466-2219。

**Arabic**

**معلومات مهمة عن اللغة:**

ربما تكون مؤهلاً للحصول على الحقوق والخدمات أدناه. فيمكثك الحصول على مترجم فوري أو خدمات الترجمة بدون رسوم. وربما تتوفر أيضًا المعلومات المكتوبة بعدة لغات بدون رسوم. وللحصول على مساعدة بلغتك، يُرجى الاتصال بخطتك الصحية على: UnitedHealthcare of California على الرقم 1-800-624-8822 / TTY: 711. وإذا احتجت لمزيد من المساعدة، يمكنك الاتصال بخط المساعدة التابع لـ DMHC على الرقم 1-888-466-2219.

**Armenian**

**ԿԱՐԵՎՈՐ ԼԵԶՎԱԿԱՆ ՏԵՂԵԿՈՒԹՅՈՒՆ՝**

Հավանական է, որ Ձեզ հասանելի լինեն հետևյալ իրավունքներն ու ծառայությունները: Կարող եք ստանալ բանավոր թարգմանչի կամ թարգմանության անվճար ծառայություններ: Հնարավոր է, որ մի շարք լեզուներով նաև առկա լինի անվճար գրավոր տեղեկություն: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել Ձեր առողջապահական ծրագիր՝ UnitedHealthcare of California 1-800-624-8822 / TTY՝ 711 համարով: Հավելյալ օգնության կարիքի դեպքում, զանգահարեք DMHC-ի Օգնության հեռախոսագիծ 1-888-466-2219 համարով:

**Cambodian**

**ព័ត៌មានសំខាន់អំពីភាសា៖**

អ្នកអាចនឹងមានសិទ្ធិ ចំពោះសិទ្ធិ និងសេវានៅខាងក្រោម។ អ្នកអាចទទួលអ្នកបកប្រែ ឬសេវាការបកប្រែ ដោយឥតគិតថ្លៃ។ ព័ត៌មានដែលបានសរសេរ ក៏អាចនឹងមានជាភាសាមួយចំនួន ដោយឥតគិតថ្លៃដែរ។ ដើម្បីទទួលជំនួយជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅតំបន់សុខភាពរបស់អ្នក នៅ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នក ត្រូវការជំនួយថែមទៀត ហៅខ្សែទូរស័ព្ទជំនួយ DMHC តាមលេខ 1-888-466-2219។



## **Farsi**

### **اطلاعات مهم در مورد زبان:**

شما ممکن است برای حقوق و خدمات زیر واجد شرایط باشید. می توانید خدمات مترجم شفاهی یا ترجمه را بدون پرداخت هزینه دریافت کنید. اطلاعات کتبی نیز ممکن است بدون پرداخت هزینه به برخی زبان ها موجود باشد. برای دریافت کمک و راهنمایی به زبان خودتان، لطفاً با برنامه درمانی: UnitedHealthcare of California به شماره 711 / TTY: 1-800-624-8822 تماس بگیرید. اگر به کمک و راهنمایی بیشتری نیاز دارید، با خط دریافت کمک و راهنمایی DMHC به شماره 1-888-466-2219 تماس بگیرید.

## **Hindi**

### **भाषा-संबंधी महत्वपूर्ण जानकारी:**

आप निम्नलिखित अधिकारों और सेवाओं के हकदार हो सकते हैं। आपको मुफ्त में एक दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी मुफ्त में उपलब्ध कराई जा सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपने स्वास्थ्य प्लान को यहाँ कॉल करें: UnitedHealthcare of California 1-800-624-8822 / TTY: 711 पर। यदि आपको अधिक सहायता की आवश्यकता है, तो DMHC Help Line को 1-888-466-2219 पर कॉल करें।

## **Hmong**

### **NCAUJ LUS TSEEM CEEB TXOG KEV TXUAS LUS:**

Tej zaum koj yuav tsim nyog tau cov cai thiab kev pab cuam hauv qab no. Koj yuav tau ib tug kws txhais lus los sis txhais ntawv pub dawb. Yuav puav leej txhais tau cov ntaub ntawv ua qee hom lus pub dawb. Kom tau kev pab rau koj hom lus, thov hu rau qhov chaw pab them nqi kho mob rau rau koj ntawm: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau DMHC Help Line ntawm tus xov tooj 1-888-466-2219.

## **Japanese**

### **言語支援サービスについての重要なお知らせ :**

お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください : UnitedHealthcare of California 1-800-624-8822 / TTY: 711。この他のサポートが必要な場合には、DMHC Help Line に 1-888-466-2219 にてお問い合わせください。

## **Korean**

### **중요 언어 정보:**

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. UnitedHealthcare of California 1-800-624-8822 / TTY: 711. 더 많은 도움이 필요하신 분은 DMHC 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

### **Punjabi**

#### **ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:**

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਬਾਸੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: UnitedHealthcare of California 1-800-624-8822 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ DMHC ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

### **Russian**

#### **ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:**

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: UnitedHealthcare of California 1-800-624-8822 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки DMHC по телефону 1-888-466-2219.

### **Tagalog**

#### **MAHALAGANG IMPORMASYON SA WIKA:**

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalin nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa DMHC Help Line sa 1-888-466-2219.

### **Thai**

#### **ข้อมูลสำคัญเกี่ยวกับภาษา :**

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังมีอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผน สุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการ ฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ DMHC ที่ หมายเลขโทรศัพท์ 1-888-466-2219

### **Vietnamese**

#### **THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:**

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: UnitedHealthcare of California 1-800-624-8822 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ DMHC theo số 1-888-466-2219.

## **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](mailto: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