UnitedHealthcare
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 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/ 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $2,000 individual / $4,000 family. For prescription drugs from participating pharmacies: For the 2024 calendar year: $7,100 individual / $14,200 family; Effective 1/1/25, for the 2025 calendar year: $7,450/individual / $14,900/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?	**Medical out-of-pocket limit (for participating providers):** Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover. **Prescription Drug Out-of-Pocket Limit (applicable to prescription drugs from network pharmacies):** 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 www.welcometouhc.com/uhcwest 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 (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay / office visit and $25 copay / Virtual visits by a designated virtual participating provider; deductible does not apply	Not covered	If you receive services in addition to office visit, additional copayments, deductibles or coinsurance may apply.
	Specialist visit	$35 copay / visit; deductible does not apply	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments, deductibles or coinsurance may apply.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-800-788-7871.	Generic	$8 copay / prescription; deductible does not apply	Not covered	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 copay plus the difference in cost between the brand drug and the generic drug unless your provider 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 plan. Not all drugs are covered.
	Formulary brand drugs (Preferred)	$25 copay / prescription; deductible does not apply	Not covered	
	Non-Formulary brand drugs (Non-Preferred)	$45 copay / prescription; deductible does not apply	Not covered	
	Preventive Care Drugs (including FDA approved Contraceptives)	No charge; deductible does not apply	Not covered	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). Preventive Care 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.
	Injectable (Specialty) Drugs	20% coinsurance; deductible does not apply	Not covered	Preauthorization 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 Prescription Drug Plan. If injectable drugs are administered in a UHC physician's office, office visit Copayment/Coinsurance may also apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	None
	Physician/surgeon fees	No charge; deductible 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)	
If you need immediate medical attention	Emergency room care	$150 copay / visit; deductible does not apply	$150 copay / visit; deductible does not apply	Copayment waived if admitted.
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	None
	Urgent care	$35 copay / visit; deductible does not apply	$75 copay / visit; deductible does not apply	If you receive services in addition to urgent care, additional copayments, deductibles or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	No charge; deductible does not apply	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay / office visit and No charge for all other outpatient services; deductible does not apply	Not covered	None
	Inpatient services	25% coinsurance; deductible does not apply	Not covered	
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments, deductibles or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$35 copay / visit; deductible does not apply	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	Not covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$35 copay / visit; deductible does not apply	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	$35 copay / visit; deductible does not apply	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Skilled nursing care	25% coinsurance	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	No charge; deductible does not apply	Not covered	None
	Hospice services	No charge; deductible does not apply	Not covered	If inpatient admission, subject to inpatient copayments, deductibles or coinsurance.
If your child needs dental or eye care	Children's eye exam	UHC: No charge Fund: No charge; deductible does not apply	UHC: Not covered Fund: No charge; deductible does not apply	UHC: None Fund: Maximum benefit of $135 per exam
	Children's glasses	UHC: Not covered Fund: You pay all charges over the Fund's allowance; deductible does not apply.		Fund: Allowed amount 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 2023 roll over for use in 2024.
	Children's dental check-up	UHC: Not covered Fund: You may elect coverage from the Indemnity Dental Plan or the United Concordia Dental HMO Plan.		Your dental coverage is not subject to health care reform.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Fund provides limited benefit of up to $120 per calendar year)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Dental care (Adult) - (available under separate Indemnity Dental Plan or United Concordia Dental HMO)
- Hearing aids – (Benefit is provided separately through the Trust Fund. Maximum benefit of $750 for each ear in a 12-month period).
- Routine eye care (Adult) - (Coverage for glasses and contacts is limited to Fund provided benefit of $135/year for exam, frame and Lenses).
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov., or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet 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, kwiijigo 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 plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,100**

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

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

Mia's Simple Fracture
(participating provider emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

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.

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

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. فيمكنك 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 لمزيدٍ 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 សូមទូរស័ព្ទទៅគំរោងសុខភាពរបស់អ្នក នៅ៖ UnitedHealthcare of California 1-800-624-8822 / TTY: 711។ បើសិនអ្នកត្រូវការជំនួយថែមទៀត 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 1-800-624-8822/TTY: 711 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 मुफ़्त में एक दुभाषिया या अनुवाद सेवाएँ उपलब्ध कराई जा सकती हैं। कुछ भाषाओं में लिखित जानकारी भी मुफ़्त में उपलब्ध कराई जा सकती हैं। 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 हैं, 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 ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਬਿਨਾ ਕਿਸੇ ਖਰਚੇ ਦੇ ਮਿਲ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ 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 คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : UnitedHealthcare of California 1-800-624-8822 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ DMHC ที่หมายเลขโทรศัพท์ 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
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