# Choice Plus 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 | Choice Plus |
|---|---|
| **International and U.S. Network and out-of-network benefits**<br>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. | ✓ |
| **Virtual Visits**<br>Talk to a doctor 24/7 who can diagnose and treat a wide range of non-emergency medical conditions, such as colds and rashes. | ✓ |
| **Vision**<br>With this plan, you have coverage for an annual eye exam. | ✓ |
| **Preventive care covered at 100%**<br>There is no additional cost to you for seeing an International or U.S. network provider for preventive care. | ✓ |
| **Pharmacy benefits**<br>With this plan, you have coverage that helps pay for prescription drugs and medications. | ✓ |
| **Evacuation & Repatriation**<br>With our program, you are covered for certain assistance benefits and services, including medical evacuations and repatriations. | ✓ |
| **Intelligence**<br>The Global Intelligence Center provides real-time, country-specific medical and security details, risks, quality of care assessments, threats and immunizations requirements. | ✓ |

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 Choice Plus works.

## Medical Benefits

| | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| **Annual Medical Deductible** | | | |
| Individual | You do not have to pay a medical deductible. | $1,000 | $2,000 |
| Family | You do not have to pay a medical deductible. | $3,000 | $6,000 |

*All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.*

*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 | $2,000 | $2,000 | $3,000 |
| Family | $6,000 | $6,000 | $9,000 |

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

### What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| **Preventive Care Services** | | | |
| Preventive Care Services<br><br>*Certain preventive care services are provided as specified 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, co-insurance or deductible.*<br><br>*Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.* | No copay | No copay | 30%* |
| **Office Services - Sickness & Injury** | | | |
| Primary Care Physician<br><br>*Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.* | No copay | $20 copay | 30%* |
| Specialist<br><br>*Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.* | No copay | $40 copay | 30%* |
| Urgent Care Center Services<br><br>*Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.* | No copay | $50 copay | 30%* |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| Virtual Visits<br><br>*Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card.* | No copay | No copay | Not covered |
| Vision Exams<br><br>*Limited to 1 exam every 12 months.*<br><br>*For U.S. Benefits find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.* | No copay | $20 copay | 30%* |
| **Emergency Care** | | | |
| Ambulance Services - Emergency Ambulance | 10% | 10%* | 10%* |
| Ambulance Services - Non-Emergency Ambulance[1] | 10% | 10%* | 30%* |
| Dental Services - Accident Only | 10% | 10%* | 10%* |
| Emergency Health Care Services - Outpatient | No copay | $200 copay | $200 copay |
| **Inpatient Care** | | | |
| Congenital Heart Disease (CHD) Surgeries[1] | 10% | 10%* | 30%* |
| Hospital - Inpatient Stay[1] | 10% | 10%* | 30%* |
| Habilitative Services - Inpatient[1]<br><br>*Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.* | The amount you pay is based on where the covered health care service is provided. | | |
| Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]<br><br>*Limited to 120 days per year in a Skilled Nursing Facility.*<br><br>*Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.* | 10% | 10%* | 30%* |
| **Outpatient Care** | | | |
| Acupuncture Services<br><br>*Limited to 25 treatments per year.* | No copay | $20 copay | 30%* |
| Habilitative Services - Outpatient<br><br>*For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.* | No copay | $20 copay | 30%* |
| Home Health Care[1]<br><br>*Limited to 120 visits per year.*<br><br>*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.* | 10% | 10%* | 30%* |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] | No copay | No copay | 30%* |
| Major Diagnostic and Imaging - Outpatient[1] | 10% | 10%* | 30%* |
| Physician Fees for Surgical and Medical Services | 10% | 10%* | 30%* |
| Rehabilitation Services - Outpatient Therapy and Manipulative Treatment<br><br>*Limited to 20 visits of physical therapy per year.*<br><br>*Limited to 30 visits of post-cochlear implant aural therapy per year.*<br><br>*Limited to 20 visits of occupational therapy per year.*<br><br>*Limited to 20 visits of cognitive rehabilitation therapy per year.*<br><br>*Limited to 36 visits of cardiac rehabilitation therapy per year.*<br><br>*Limited to 20 visits of speech therapy per year.*<br><br>*Limited to 20 visits of pulmonary rehabilitation therapy per year.*<br><br>*Limited to 20 visits of manipulative treatments per year.*<br><br>*Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of pervasive developmental disorder or Autism Spectrum Disorders.* | No copay | $20 copay | 30%* |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic<br><br>*Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.* | 10% | 10%* | 30%* |
| Surgery - Outpatient[1] | 10% | 10%* | 30%* |
| Therapeutic Treatments - Outpatient[1] | 10% | 10%* | 30%* |
| Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1] | No copay | No copay | 30%* |
| **Supplies and Services** | | | |
| Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1] | The amount you pay is based on where the covered health care service is provided. | | |
| Durable Medical Equipment (DME), Orthotics and Supplies[1]<br><br>*Limited to a single purchase of a type of DME or orthotic every three years.*<br><br>*Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.* | 10% | 10%* | 30%* |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| Hearing Aids<br><br>*Limited to $5,000 every year.*<br><br>*Limited to a single purchase per hearing impaired ear every three years.*<br><br>*Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.* | 10% | 10%* | 30%* |
| Ostomy Supplies | 10% | 10%* | 30%* |
| Pharmaceutical Products - Outpatient<br><br>*This includes medications given at a doctor's office, or in a covered person's home.* | 10% | 10%* | 30%* |
| Prosthetic Devices[1] | 10% | 10%* | 30%* |
| **Pregnancy** | | | |
| Pregnancy - Maternity Services[1]<br><br>*We pay for Covered Health Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.*<br><br>*All maternity items and services that are recommended preventive care and are required to be covered under the Affordable Care Act, will be provided without cost share. Please refer to Preventive Care Services below.*<br><br>*Prenatal care office visits received from a Network provider are covered without cost sharing during the entire course of the Covered Person's pregnancy.* | 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. | | |
| **Mental Health Care & Substance Related and Addictive Disorder Services** | | | |
| Inpatient[1] | 10% | 10%* | 30%* |
| Outpatient Office Visits[1] | No copay | $20 copay | 30%* |
| All Other Outpatient Treatment[1] | 10% | 10%* | 30%* |
| **Other Services** | | | |
| Breast Cancer Services[1] | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |
| Clinical Trials[1]<br><br>*To be a qualifying clinical trial for services outside the United States, a clinical trial must meet all of the criteria as described under Clinical Trials in the Certificate of Coverage.* | The amount you pay is based on where the covered health care service is provided. | | |
| Culturally Based Services | 10% | Benefits are not available | Benefits are not available |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| Dental Anesthesia Services<br><br>*Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; or a person whose health is compromised and for whom general anesthesia is required, regardless of age.* | Benefits are not available. | 10%* | 30%* |
| Diabetes Treatment[1]<br><br>*Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.* | The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Prescription Drug Benefits Section. | | |
| Fertility Preservation for Iatrogenic Infertility<br><br>*Limited to $20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*<br><br>*Limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.* | Benefits are not available. | 10%* | 30%* |
| Gender Dysphoria Inpatient | 10% | 10%* | 30%* |
| Gender Dysphoria Outpatient Office Visits | No copay | $20 copay | 30%* |
| Gender Dysphoria All Other Outpatient Office Visits<br><br>*Outpatient prescription drugs for the treatment of gender dysphoria are subject to the cost share as noted in the Outpatient Prescription Drug Schedule of Benefits.* | 10% | 10%* | 30%* |
| Hospice Care[1] | 10% | 10%* | 30%* |
| Mastectomy Services[1] | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |
| Obesity - Weight Loss Surgery[1]<br><br>*Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.* | The amount you pay is based on where the covered health care service is provided. | | Not covered |
| Off-Label Drug Use and Experimental or Investigational Services | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |
| Osteoporosis Services | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |
| Phenylketonuria (PKU) Treatment[1] | Benefits are not available. | 10%* | 30%* |
| Prosthetic Devices - Laryngectomy[1] | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

## What You Pay for Services

| Copays ($) and Coinsurance (%) for Covered Health Care Services | International | U.S. Network | U.S. Out-of-Network |
|---|---|---|---|
| Reconstructive Procedures[1] | The amount you pay is based on where the covered health care service is provided. | | |
| Telehealth Services | Benefits are not available. | The amount you pay is based on where the covered health care service is provided. | |
| Temporomandibular Joint (TMJ) Services[1] | The amount you pay is based on where the covered health care service is provided. | | |
| Transplantation Services[1] | The amount you pay is based on where the covered health care service is provided. | | Not covered |
| Vision Materials<br><br>*Benefits for these services will be paid as reimbursements. When obtaining these services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us.*<br><br>*Includes Eyeglass Frames, Eyeglass Lenses, and Contact Lenses.*<br><br>*Limited to a maximum reimbursement of $100 every 12 months.* | No copay | No copay | No copay |
| Wigs<br><br>*Limited to $600 every 24 months.* | 10% | 10%* | 30%* |
| **Evacuation and Repatriation Services** | | | |
| Emergency Evacuation[1]<br><br>*Limited to a per diem of $300 for up to 30 days towards the living expenses incurred by the person(s) accompanying you.* | No copay | Benefits are not available | Benefits are not available |
| Emergency Family Reunion[1]<br><br>*Limited to a per diem for living expenses for immediate family members of $300 while the Covered Person is hospitalized up to 30 days.* | No copay | Benefits are not available. | Benefits are not available |
| Medical Repatriation[1]<br><br>*Benefits include Repatriation of Children (under age 18) and adult family members.* | No copay | Benefits are not available | Benefits are not available |
| Repatriation of Remains[1]<br><br>*Benefits include Return of Children (under age 18) and adult family members.* | No copay | Benefits are not available. | Benefits are not available |
| **International Pharmacy Benefits** | | | |
| Outpatient Prescription Drugs<br><br>*Prescriptions must be paid for out-of-pocket and submitted to us for reimbursement.* | 10% | Benefits are not available | Benefits are not available |

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

# U.S. Pharmacy Benefits

| Pharmacy Plan Details | |
|---|---|
| Pharmacy Network | National |
| Prescription Drug List | Advantage |

**U.S. In Network and Out of Network**

| Annual Pharmacy Deductible | |
|---|---|
| Individual | You do not have to pay a pharmacy deductible |
| Family | You do not have to pay a pharmacy deductible |

| Prescription Drug Product Tier Level | Up to a 31-day supply | | Up to a 90-day supply |
|---|---|---|---|
| | U.S. Retail Network | U.S. Out-of-Network Pharmacy | U.S. Mail Order Network Pharmacy** |
| **Tier 1 $** | $20 | 20% | $50 |
| **Tier 2 $$** | $40 | 20% | $100 |
| **Tier 3 $$$** | $75 | 20% | $187.50 |

* After the Annual Pharmacy Deductible has been met.

** 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.

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.

For members that need to take their prescription drugs with them outside the United States, up to 365 day supply may be obtained with a prescription from a Network provider. Certain limitations may apply, such as controlled narcotics or drugs with a limited shelf-life.

# 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.

- Private-Duty Nursing
- Weight Loss Programs
- Long-Term Care
- Cosmetic Surgery
- Infertility Treatment
- Glasses
- Routine Foot Care

### Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's 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 a mail order Network 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 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) 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 a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network 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 a mail order Network 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.

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility unless required by state law.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Certain Prescription Drug Products for tobacco cessation.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- 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.
- Certain compounded drugs.
- Medications used for cosmetic purposes.
- Diagnostic kits and products.
- Durable Medical Equipment, including 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.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Experimental or Investigational or Unproven Services and medications.
- 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.
- Growth hormone therapy unless required by state law.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
- Drugs available over-the-counter.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Prescription Drug Products when prescribed as sleep aids.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.

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**

**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.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة العضوية الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

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

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

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

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

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

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

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

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 kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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 વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



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