

# Summary Plan Description

**Public Employees Benefit Cooperative (PEBC)  
Parker County  
Limited Flexible Spending Account Plan**

Effective: January 1, 2022

Group Number: 918916



the 1990s, the number of people in the world who are undernourished has increased from 600 million to 800 million (FAO 1999).

There are a number of reasons why the world's population is becoming more food insecure. The most important are the increasing demand for food, the increasing demand for land, and the increasing demand for water.

The increasing demand for food is due to the increasing population and the increasing demand for meat and dairy products.

The increasing demand for land is due to the increasing demand for agricultural land and the increasing demand for land for urban and industrial development.

The increasing demand for water is due to the increasing demand for water for agriculture and the increasing demand for water for urban and industrial development.

The increasing demand for food, land, and water is leading to a number of problems, including deforestation, soil erosion, and water pollution.

These problems are leading to a number of problems, including food insecurity, malnutrition, and poverty.

There are a number of ways to address these problems, including increasing agricultural productivity, reducing food waste, and improving water management.

These measures are essential for ensuring that the world's population has access to enough food, land, and water to meet its needs.

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## **FLEXIBLE SPENDING ACCOUNT PLAN**

### **Notice To Employees**

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2022.

Public Employees Benefit Cooperative (PEBC) Parker County has entered into an arrangement with United Healthcare Services, Inc., Minnetonka, MN ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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## PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

The **Limited Health Care Spending Account ("LHCSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses, including certain vision and dental expenses for you, your spouse, your dependent children, and any other dependents as determined by Public Employees Benefit Cooperative (PEBC) Parker County and in compliance with the Internal Revenue Code (IRC).

The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in either the LHCSA, the DCSA, or both.

Each Plan year (January 1 through December 31) you can contribute to your LHCSA and/or DCSA and then, during the Plan year, you can receive reimbursement for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, *Contributions*.

## WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

### Who is Eligible

A regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 30 hours per week is eligible to participate in the Plan.

### When You May Enroll

Newly hired employees must return enrollment documents to the Payroll and Benefits Service Center within 14 days of the date you begin working. If timely elected, the Plan will be effective on the first day of the month after 30 consecutive calendar days of active, regular employment. If you do not elect to participate in the Plan as a newly hired employee, you must wait until the next annual Open Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) You will need to enroll each year, even if you enrolled in the Plan the year before.

### How to Enroll

You elect to participate in the Plan by completing enrollment online and submitting it to the Parker County Payroll and Benefits Service Center. You must specify the amount of before-tax dollars you wish to contribute to the LHCSA, the DCSA, or both.

Each year during annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the LHCSA, the DCSA, or both. Any changes you make during Open Enrollment will become effective the following January 1.

## **CONTRIBUTIONS**

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded." Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year.

### ***Health Care Spending Account Contributions***

For the Health Care Spending Account, you may elect to contribute between \$0 and \$2,750 a year.

### ***Dependent Care Spending Account Contributions***

For the Dependent Care Spending Account, you may elect to contribute between \$0 and \$5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to \$2,500 a year. If you or your spouse's earned income is less than \$5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

## **BENEFIT PAYMENTS**

### ***Health Care Spending Account***

IRS regulations permit the forfeiture of any unused funds remaining in the account at the end of the Plan year except that a portion of your remaining health care FSA funds may automatically roll over into your account for the next plan year.

You have until April 30 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year.

### ***A portion of your remaining health care FSA funds will automatically roll over into your account for the next plan year***

If you don't spend all the funds in your FSA during the initial year, your employer allows a portion of your remaining FSA balance to automatically roll over into your account for another plan year. The maximum amount that can be rolled over at the end of the plan year is limited to \$500.

The Plan allows you to spend down the remaining balance in the Health Care FSA even if you do not re-enroll in the Health Care FSA. The rollover is available for one year. You forfeit any unused rollover funds remaining in the account after one year.

Your rollover amount may be used to pay or reimburse medical expenses incurred during the entire Plan year to which it is carried over. New plan year expenses are reimbursed from

the new plan year's salary reduction election first. This allows the carryover amount to remain available for the prior plan year's expenses during the run-out period.

Since a rollover is offered under this Plan, this FSA plan does not allow for a grace period.

### ***Dependent Care Spending Account***

IRS regulations require that you forfeit any unused funds remaining in the account at the end of the Plan year.

You have until April 30 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year.

For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. Any such Eligible Dependent Care Expenses must be submitted on or before April 30 of the Plan year following your termination.

## **CHANGING YOUR CONTRIBUTION AMOUNTS**

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you meet one of the following conditions:

- A. With regard to both a LHCSA and a DCSA, one of the following changes in status events occurs:
  - An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
  - An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
  - An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
  - An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the LHCSA or DCSA.
- B. For individuals who participate in a LHCSA, the following additional events will enable you to change your election:
  - If you become entitled to Medicare or Medicaid, you may elect to revoke your LHCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
  - If the FSA Plan Sponsor and/or Public Employees Benefit Cooperative (PEBC) Parker County receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator and/or Public Employees Benefit Cooperative (PEBC) Parker County may:



- ◆ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the LHCSA, or
- ◆ Permit you to cancel your child's coverage under the LHCSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Public Employees Benefit Cooperative (PEBC) Parker County within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your LHCSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts made during the Plan year are effective as of the first of the month following the date that you timely notify Public Employees Benefit Cooperative (PEBC) Parker County of the change in status.

## **LIMITED HEALTH CARE SPENDING ACCOUNT**

### **Eligible Health Care Expenses**

To be eligible for reimbursement from your LHCSA, the health care expenses must be all of the following:

- Incurred while you are participating in the LHCSA.
- Incurred during the Plan year.

#### **Please note**

Any reimbursement you receive through your LHCSA cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your LHCSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of Eligible Expenses are available at [www.myuhc.com](http://www.myuhc.com). Some guidance regarding what constitutes eligible dental and vision expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website [www.irs.gov](http://www.irs.gov) or by phone at 1-800-TAX-FORM (1-800-829-3676).

***Eligible Vision Expenses***

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

***Eligible Dental Expenses***

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

***Ineligible Expenses***

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Insurance premiums, long term care premiums, and other payments or contributions for dental and vision coverage (such as contributions for coverage under an employer-sponsored group dental or vision plan or HMO or other dental or vision plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through your LHCSA cannot be claimed as deductions on your income tax return.

## **DEPENDENT CARE SPENDING ACCOUNT**

### **Eligible Dependent Care Expenses**

Eligible Dependent Care Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of \$250 (as adjusted from time to time) if you have one dependent, or \$500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

## **Dependent Care Tax Credit vs. Dependent Care Spending Account**

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

## **HEALTH CARE SPENDING CARD DEBIT MASTERCARD®**

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from your LHCSA and/or DCSA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

### **Important**

You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to **myuhc.com** to learn how to get the most out of your Health Care Spending Card Debit MasterCard®.

## **Receiving Your Health Care Spending Card Debit MasterCard®**

You will automatically receive two Health Care Spending Card Debit MasterCard®s. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

## **Activating Your Health Care Spending Card Debit MasterCard®**

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real-time upon activation of the card within the first Plan year. However, for future Plan years the funds will not be available for use until the effective date of the future Plan year.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from Public Employees Benefit Cooperative (PEBC) Parker County or found on **myuhc.com** and as described under Section, *Requesting a Reimbursement from Your Flexible Spending Account* or for Eligible Health Care Expenses by using the automatic reimbursement (auto-rollover) feature described under the Section, *Automatic Reimbursement (Auto-Rollover)*.

**Please note**

If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

## **Qualified Locations and Providers**

The Health Care Spending Card Debit MasterCard® may be used at any approved provider with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the provider accepts MasterCard®. Examples of qualified locations and providers include dental offices, vision care providers, and child and adult day care facilities.

## **Using the Health Care Spending Card Debit MasterCard®**

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard® because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified dental or vision expense or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under Section, *Limited Health Care Spending Account* and *Dependent Care Spending Account*. A claim number is assigned to the transaction.

## **Eligible Expenses Reimbursed through the Health Care Spending Card Debit MasterCard®**

Your card can be used for certain Eligible Dependent Care Expenses and Eligible Health Care Expenses including copayments, deductibles and coinsurance at dental and vision provider locations associated with dental and vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. While in-network provider transactions can be used for coinsurance and deductibles the card does not determine patient responsibility or eligible benefits.

## **Partial Payment Authorization**

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your LHCSA for a portion of the transaction at providers that accept partial authorization. For example, if

your visit with the dentist costs \$20 and you only have \$10 remaining in your LHCSA, the LHCSA balance of \$10 will be authorized towards the visit with your dentist and you are responsible for paying the remaining balance of \$10 with another form of payment. Note: not all providers accept partial authorization.

### Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on [www.myuhc.com](http://www.myuhc.com). If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

#### Getting help 24 hours a day is easy.

Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.

- Learn your account balance.
- Report a lost or stolen card.
- Order extra cards and more.

Go onto **myuhc.com** anytime.

- Learn your account balance.

### REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your Health Care Spending Card Debit MasterCard® or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your LHCSA and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from Public Employees Benefit Cooperative (PEBC) Parker County or can be found on **[www.myuhc.com](http://www.myuhc.com)**. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic Reimbursement (Auto-Rollover)* is turned "on" you will not have to submit a reimbursement form for certain LHCSA expenses.

For reimbursement from your LHCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice or an Explanation of Benefits (EOB) from any group dental or vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group dental plans are made.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. For the DCSA, if your employment terminates you can

continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your LHCSA or DCSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as daily. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least \$25, except for reimbursement with respect to the last month of the Plan year. Amounts below \$25 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described under Section, *Automatic Reimbursement (Auto-Rollover)* is turned "on" you will not have to submit a reimbursement form for certain LHCSA expenses.

If you have established an LHCSA, your total annual contribution is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through April 30 of the following year for expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account terminated. Any such Eligible Dependent Care Expenses must be submitted on or before April 30 of the Plan year following your termination.

**In accordance with IRS regulations, amounts contributed to your LHCSA or DCSA during the Plan year but remaining in your account at the end of the processing period (April 30 of the following year) can not be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.**

**Important**

**Myuhc.com** includes many features such as the options to:

- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

## **Automatic Reimbursement (Auto-Rollover)**

Your employer has elected to have Eligible Expenses for dental and vision claims which are not covered under your UnitedHealthcare administered plans automatically submitted to your LHCSA for reimbursement and automatically reimbursed from your LHCSA without further action by you. This eliminates extra paperwork and makes it more convenient for you to use your LHCSA. Automatic Reimbursement (Auto-rollover) is turned "on" at the start of the Plan year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to **www.myuhc.com**. All claims must still be verified and UnitedHealthcare may request additional substantiation.

However, if you have dental and vision coverage through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to your domestic partner covered under your employer's group health plan, unless your domestic partner is your federal tax dependent for health coverage purposes, as defined under Section 105(b) of the IRS Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

## **CLAIMS PROCEDURES**

### **Claim Denials and Appeals**

#### ***If Your Claim is Denied***

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your Health Care Spending Card Debit MasterCard® card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

#### ***How to Appeal a Denied Claim***

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of dental and vision service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals  
Attn Appeals  
P.O. Box 981512  
El Paso, TX 79998-1512



***Review of an Appeal***

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

***Filing a Second Appeal***

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Public Employees Benefit Cooperative (PEBC) Parker County within 60 days from receipt of the first level appeal. Public Employees Benefit Cooperative (PEBC) Parker County must notify you of the benefit determination within 30 days after receiving the completed appeal.

**Note:** Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Public Employees Benefit Cooperative (PEBC) Parker County will review all claims in accordance with the rules established by the U.S. Department of Labor. Public Employees Benefit Cooperative (PEBC) Parker County's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

| Claim Denial and Appeals  |   |
|---|---|
| Type of Claim or Appeal   | Timing  |
| If your claim is incomplete, UnitedHealthcare must notify you within:               | <b>30 days</b>                                      |
| You must then provide completed claim information to UnitedHealthcare within:       | <b>45 days</b> after receiving an extension notice* |
| If UnitedHealthcare denies your initial claim, they must notify you of the denial:  |   |
| ▪ if the initial claim is complete, within:   | <b>30 days</b>                                      |
| ▪ after receiving the completed claim (if the initial claim is incomplete), within: | <b>30 days</b>                                      |
| You must appeal the claim denial no later than:                                     | <b>180 days</b> after receiving the denial          |

| Claim Denial and Appeals  |  |
|---|--|
| Type of Claim or Appeal   | Timing   |
| UnitedHealthcare must notify you of the first level appeal decision within:   | <b>30 days</b> after receiving the first level appeal          |
| You must appeal the first level appeal (file a second level appeal) within:   | <b>60 days</b> after receiving the first level appeal decision |
| Public Employees Benefit Cooperative (PEBC) Parker County must notify you of the second level appeal decision within: | <b>30 days</b> after receiving the second level appeal         |

\*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

## WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

## Limited Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before April 30 of the next Plan year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Limited Health Care Spending Account Plan. You should call Public Employees Benefit Cooperative (PEBC) Parker County to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

## Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

This optional continuation coverage only applies if it has been made available by Public Employees Benefit Cooperative (PEBC) Parker County. Public Employees Benefit Cooperative (PEBC) Parker County may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask Public Employees Benefit Cooperative (PEBC) Parker County to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if Public Employees Benefit Cooperative (PEBC) Parker County or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's LHCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by Public Employees Benefit Cooperative (PEBC) Parker County on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

### **Uniformed Services Employment and Reemployment Rights Act**

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the LHCSA. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the LHCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the LHCSA, if the employee returns to a position of employment, the employee's LHCSA and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the LHCSA under USERRA.

UnitedHealthcare is not Public Employees Benefit Cooperative (PEBC) Parker County's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

### **Dependent Care Spending Account**

You may submit claims for the Eligible Expenses you have incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date, against what is in your DCSA balance at the time of termination. Any such claims must be submitted on or before April 30 of the next Plan year.

## ATTACHMENT I – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

| <b>Claims Administrator Civil Rights Coordinator</b>  |
|---|
| <b>United HealthCare Services, Inc Civil Rights Coordinator</b><br>UnitedHealthcare Civil Rights Grievance<br>P.O. Box 30608<br>Salt Lake City, UT 84130<br>The toll-free member phone number listed on your health plan ID card, TTY 711<br>UHC_Civil_Rights@UHC.com |

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

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

## ATTACHMENT II – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

| Language                     | Translated Taglines  |
|------------------------------|--|
| 1. Albanian                  | Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.  |
| 2. Amharic                   | ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከራሉን በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711  |
| 3. Arabic                    | لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711  |
| 4. Armenian                  | Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711  |
| 5. Bantu-Kirundi             | Urafise uburenganzira bwo kuronka ubufasha n’amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomeru ya telephone y’ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k’umugambi wawe w’ubuzima, fyonda 0. TTY 711              |
| 6. Bisayan-Visayan (Cebuano) | Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711 |
| 7. Bengali-Bangala           | অনুবাদের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711   |
| 8. Burmese                   | ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711    |

| Language                         | Translated Taglines  |
|----------------------------------|--|
| 9. Cambodian-Mon-Khmer           | អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនគិតថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711   |
| 10. Cherokee                     | Ꭰ ᎠᎩᎠ ᎠᎩ ᎠᎩᎩᎩ ᎠᎩᎩᎩ ᎠᎩᎩᎩ ᎠᎩ ᎠᎩᎩ ᎠᎩ ᎠᎩᎩ ᎠᎩᎩᎩ ᎠᎩᎩᎩᎩ, ᎠᎩᎩᎩᎩ ᎠᎩ. TTY 711  |
| 11. Chinese                      | 您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按0。聽力語言殘障服務專線 711   |
| 12. Choctaw                      | Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu hᎠ ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila hᎠ ish iᎩpaya cha 0 ombetipa. TTY 711               |
| 13. Cushite-Oromo                | Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711   |
| 14. Dutch                        | U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711  |
| 15. French                       | Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711. |
| 16. French Creole-Haitian Creole | Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711   |
| 17. German                       | Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711   |
| 18. Greek                        | Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711   |



| Language       | Translated Taglines   |
|----------------|---|
| 19. Gujarati   | તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711  |
| 20. Hawaiian   | He pono ke kōkua ‘ana aku iā ‘oe ma ka maopopo ‘ana o kēia ‘ike ma loko o kāu ‘ōlelo pono ‘ī me ka uku ‘ole ‘ana.<br>E kama‘ilio ‘oe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ‘ole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.                      |
| 21. Hindi      | आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फोन करें, 0 दबाएं। TTY 711   |
| 22. Hmong      | Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.  |
| 23. Ibo        | Inwere ikike inweta enyemaka nakwa imuta asusu gi n'efu n'akwughị ugwo. Maka ikpọturu onye nsughari okwu, kpoo akara ekwentị nke di n'akwukwo njirimara gi nke emere maka ahụike gi, pia 0. TTY 711.  |
| 24. Ilocano    | Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711 |
| 25. Indonesian | Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711                              |
| 26. Italian    | Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711               |

| Language                  | Translated Taglines  |
|---------------------------|--|
| 27. Japanese              | ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711 です。   |
| 28. Karen                 | မူအိဉ်ဒီးတၢ်ခွဲတၢ်ဖၢလၢနကဒီးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂၢၢ်တၢ်ကျိၤလၢနကဒီးန့ၢ်ဒုဝဲလၢတၢ်လိၣ်ဟ့ၣ်အပူၤဘၣ်န့ၣ်လီၤလၢတၢ်ကယုန့ၢ်ပုၤကတိၤကျိၤထံတၢ်တကၤအဂီၢ်ကိးဘၣ်လိၣ်တဲၤအကျိၤလၢကရၢဖိအတၢ်လိၣ်ဟ့ၣ်အပူၤလၢအိဉ်လၢနတၢ်အိဉ်ဆူၣ်အိဉ်ဆူၣ်တၢ်ရဲၣ်တၢ်ကျဲၤအကးအလံးဒီးဆိၣ်လိၣ်နီၢ်ဂံၢ် 0 တကျဲၤ.TTY 711 |
| 29. Korean                | 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711  |
| 30. Kru- Bassa            | Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711   |
| 31. Kurdish-Sorani        | مافه‌ی ته‌وه‌ت هه‌یه که بێهه‌رامبه‌ر، یارمه‌تی و زانیاری پێویست به‌ زمانێ خۆت وهرگریت. بۆ داواکردنی وهرگیرێکی زارمه‌کی، په‌یوه‌ندی بکه به‌ ژماره‌ ته‌له‌فۆنی نووسراو له‌ناو ئای دی کارتی پیناسه‌یی پلانی ته‌ندروستی خۆت و پاشان 0 داگره‌ .TTY 711                      |
| 32. Laotian               | ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ.<br>ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711  |
| 33. Marathi               | आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबद्ध केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711  |
| 34. Marshallese           | Eor aṃ maroñ ñan bok jipañ im mejeje ilo kajin eo aṃ ilo ejjeļok wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūļok nōmba eo emōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711  |
| 35. Micronesian-Pohnpeian | Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, ekerelepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.   |

| Language               | Translated Taglines  |
|------------------------|--|
| 36. Navajo             | T'áá jíík'eh doo bááh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee níká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'i la yíníkeedgo, ninaaltsoos nit[ 'iz7 'ats'77s bee baa'ahay1 bee n44hazin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodílnih dóó 0 bíł 'adidíłchíł. TTY 711 |
| 37. Nepali             | तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाउँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711  |
| 38. Nilotic-Dinka      | Yín nōŋ lōŋ bē yi kuōny nē wēřēyic de thōŋ du ābac ke cin wēu tāāue ke piny. Ācān bā ran yē kōc ger thok thiēc, ke yin cōl nāmba yene yup abac de ran tōŋ ye kōc wāār thok tō nē ID kat duōn de pānakim yic, thāny 0 yic. TTY 711.   |
| 39. Norwegian          | <b>Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711</b>  |
| 40. Pennsylvania Dutch | Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711  |
| 41. Persian-Farsi      | شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711   |
| 42. Punjabi            | ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।   |
| 43. Polish             | Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wcisnij 0. TTY 711  |
| 44. Portuguese         | Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711   |
| 45. Romanian           | Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711   |



| Language                  | Translated Taglines  |
|---------------------------|--|
| 55. Thai                  | คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย<br>หากต้องการขอล่ามแปลภาษา<br>โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0<br>สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรถึงหมายเลข 711  |
| 56. Tongan-<br>Fakatonga  | ‘Oku ke ma’u ‘a e totonu ke ma’u ‘a e tokoni mo e ‘u fakamatala ‘i<br>ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki<br>he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o<br>kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711                      |
| 57. Trukese<br>(Chuukese) | Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe<br>aninis ika toropwen aninis nge epwe awewetiw non kapasen<br>fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku,<br>kori ewe member nampa, ese pwan kamo, mi pachanong won an<br>noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711. |
| 58. Turkish               | Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız<br>bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın<br>üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a<br>basınız. TTY (yazılı iletişim) için 711   |
| 59. Ukrainian             | У Вас є право отримати безкоштовну допомогу та інформацію на<br>Вашій рідній мові. Щоб подати запит про надання послуг<br>перекладача, зателефонуйте на безкоштовний номер телефону<br>учасника, вказаний на вашій ідентифікаційній карті плану<br>медичного страхування, натисніть 0. TTY 711                 |
| 60. Urdu                  | آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان<br>سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ<br>پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711  |
| 61. Vietnamese            | Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của<br>quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng<br>gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID<br>chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711   |
| 62. Yiddish               | איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון<br>אפצאל. צו פארלאנגען א דאלמעטשער, רופט<br>דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID<br>קארטל, דרוקט 0. TTY 711  |
| 63. Yoruba                | O ní ẹtọ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ láìsanwọ. Látí bá<br>ògbufọ kan sọrọ, pè sọrí nọmbà ẹrọ ibánisọrọ láìsanwọ ibodè tí a tò<br>sọrí kádi idánimọ tí ètò ilera rẹ, tẹ ‘0’. TTY 711   |



