

 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 or by calling 1-800-782-3158. 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 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall deductible? | Designated <u>Network</u> and <u>Network</u> : \$3,750 Individual / \$7,500 Family out-of- <u>Network</u> : \$7,500 Individual / \$15,000 Family Per calendar year. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> and categories with a <u>copay</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | Designated <u>Network</u> and <u>Network</u> : \$8,550 Individual / \$17,100 Family out-of- <u>Network</u> : \$15,000 Individual / \$30,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See www.welcometouhc.com or call 1-800-782-3158 for a list of <u>network providers</u> . | You pay the least if you use a <u>provider</u> in the Designated <u>Network</u> . You pay more if you use a <u>provider</u> in the <u>Network</u> . You will pay the most if you use an <u>out-of-<u>Network</u> provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>Network provider</u> might use an <u>out-of-<u>Network</u> provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 |
|--|--|---|--|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network 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 | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply | \$60 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. Virtual visits (Telehealth) - No Charge by a Designated Virtual <u>Network Provider</u> . No virtual coverage for out-of- <u>Network</u> . |
| | Specialist visit | \$70 <u>copay</u> per visit, <u>deductible</u> does not apply | \$100 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. |
| | Preventive care/screening/immunization | No Charge | No Charge | * Not Covered | Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. *Certain services are covered when using an out-of- <u>Network</u> . |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Out-of- <u>Network</u> Lab is not covered. <u>Preauthorization</u> required for out-of- <u>Network</u> for certain services or benefit reduces to 50% of allowed. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com . | Tier 1 - Your Lowest-Cost Option | <u>Deductible does not apply. Retail: \$10 copay</u> Mail-Order: \$25 copay | <u>Deductible does not apply. Retail: \$10 copay</u> Mail-Order: \$25 copay | <u>Deductible does not apply. Retail: \$10 copay</u> | Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network Pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Certain preventive medications and Tier 1 contraceptives are covered at No Charge. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. |
| | Tier 2 - Your Midrange-Cost Option | <u>Deductible does not apply. Retail: \$35 copay</u> Mail-Order: \$87.50 copay | <u>Deductible does not apply. Retail: \$35 copay</u> Mail-Order: \$87.50 copay | <u>Deductible does not apply. Retail: \$35 copay</u> | |
| | Tier 3 - Your Midrange-Cost Option | <u>Deductible does not apply. Retail: \$80 copay</u> Mail-Order: \$200 copay | <u>Deductible does not apply. Retail: \$80 copay</u> Mail-Order: \$200 copay | <u>Deductible does not apply. Retail: \$80 copay</u> | |
| | Tier 4 - Additional High-Cost Options | <u>Deductible does not apply. Retail: \$350 copay</u> Mail-Order: \$875 copay | <u>Deductible does not apply. Retail: \$350 copay</u> Mail-Order: \$875 copay | <u>Deductible does not apply. Retail: \$350 copay</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | 50% coinsurance | Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$500 copay per visit before deductible. After copay, 20% coinsurance | \$500 copay per visit before deductible. After copay, 20% coinsurance | \$500 copay per visit before deductible. After copay, 20% coinsurance | None |
| | <u>Emergency medical transportation</u> | 20% coinsurance | 20% coinsurance | 20% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|--|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network Provider (You will pay the most) | |
| | <u>Urgent care</u> | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply | \$30 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | <u>Network partial hospitalization</u> /intensive outpatient treatment: 20% <u>coinsurance</u> <u>Preauthorization</u> required for certain services for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |
| | Inpatient services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |
| If you are pregnant | Office visits | No Charge | No Charge | 50% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 50% <u>coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Inpatient preauthorization</u> apply for out-of- <u>Network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Limited to 364 visits per calendar year. <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |
| | <u>Rehabilitation services</u> | \$60 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply | \$60 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cardiac & Pulmonary Unlimited. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|--|--|---|---|
| | | Designated Network Provider (You will pay the least) | Network Provider | Out-of-Network Provider (You will pay the most) | |
| | <u>Habilitation services</u> | \$60 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply | \$60 <u>copay</u> per outpatient visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cost share applies for outpatient services only. <u>Preauthorization</u> required for out-of- <u>Network</u> inpatient services or benefit reduces to 50% of allowed. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Skilled nursing is limited to 100 days per calendar year . <u>Preauthorization</u> required for out-of- <u>Network</u> or benefit reduces to 50% of allowed. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Not covered | None |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Preauthorization</u> required for out-of- <u>Network</u> before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed. |
| If your child needs dental or eye care | Children's eye exam | \$10 <u>copay</u> per visit, <u>deductible</u> does not apply | \$10 <u>copay</u> per visit, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | One exam every 12 months. |
| | Children's glasses | \$25 <u>copay</u> per frame, <u>deductible</u> does not apply | \$25 <u>copay</u> per frame, <u>deductible</u> does not apply | 50% <u>coinsurance</u> | One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit does not cover both. |
| | Children's dental check-up | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | 50% <u>coinsurance</u> | Cleanings covered 2 times per 12 months. |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.) | | | | |
|--|------------------------|-----------------------|------------------|--|
| • Acupuncture | • Cosmetic Surgery | • Dental Care (Adult) | • Long-Term Care | • Non-emergency care when traveling outside the U.S. |
| • Routine Foot Care | • Weight Loss Programs | | | |

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

- Bariatric Surgery
- Hearing Aids
- Infertility Treatment - artificial insemination only
- Private Duty Nursing - Inpatient only
- Routine eye care (Adult)-1 exam/12 months
- Spinal Manipulations-20 visits per calendar year

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 is: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-800-782-3158. 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: 1-800-782-3158 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Division of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

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 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 1-800-782-3158.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3158.

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijijigo holne' 1-800-782-3158.

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 in-network pre-natal care and a hospital delivery)

| | |
|--|----------|
| ■ <u>The plan's overall deductible</u> | \$ 3,750 |
| ■ <u>Specialist copayment</u> | \$100 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal 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: | |
| <i>Cost Sharing</i> | |
| <u>Deductible</u> | \$3,700 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,170 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|----------|
| ■ <u>The plan's overall deductible</u> | \$ 3,750 |
| ■ <u>Specialist copayment</u> | \$100 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% |

This EXAMPLE event includes services like:

Primary care physician office visits (*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: | |
| <i>Cost Sharing</i> | |
| <u>Deductible</u> | \$200 |
| <u>Copayments</u> | \$1,000 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,200 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|----------|
| ■ <u>The plan's overall deductible</u> | \$ 3,750 |
| ■ <u>Specialist copayment</u> | \$100 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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: | |
| <i>Cost Sharing</i> | |
| <u>Deductible</u> | \$2,200 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,400 |

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

Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

| | |
|--|--|
| INSURANCE COMPANY NAME | UnitedHealthcare Insurance Company |
| NAME OF PLAN | Choice Plus CBWZ /E52 |
| 1. Type of Policy | Small Employer Group Policy |
| 2. Type of Plan | Point of service (POS) |
| 3. Areas of Colorado where plan is available | Plan is available only in the following areas: Adams, Alamosa Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chafee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, Eagle, El Paso, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Huerfano, Jefferson, Kiowa, Kit Carson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Miguel, Sedgwick, Summit, Teller, Washington, Weld & Yuma. |

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

| | Description |
|---|--|
| 4. Annual Deductible Type | INDIVIDUAL - The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY - The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals. |
| 5. Out-of-Pocket Maximum | INDIVIDUAL - The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY - The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals. |
| 6. What is included in the In-Network Out-of-Pocket Maximum? | Copayments and Deductibles |
| 7. Is pediatric dental covered by this plan? Maximum? | Yes, pediatric dental is subject to the medical deductible and out-of-pocket |
| 8. What cancer screenings are covered? | Breast Cancer Screening - Cervical Cancer Screening - Colorectal Cancer Screening - Prostate Cancer Screening. |

USING THE PLAN

| | IN-NETWORK | OUT-OF-NETWORK |
|---|------------|----------------|
| 9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference? | No | Yes |
| 10. Does the plan have a binding arbitration clause? | No | |

Questions: Call 1-800-516-3344 or visit us at www.UnitedHealthcare.com.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: insurance@dora.state.co.us

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-782-3158

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3158

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-782-3158

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijigo holne' 1-800-782-3158

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, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

| | | |
|---|------------|--|
| 1 | Spanish | Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711 |
| 2 | Vietnamese | Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711 |
| 3 | 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 |
| 4 | 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 |
| 5 | Russian | Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711 |
| 6 | Amharic | ያለ ምን ምን ፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አለችሁ። አስተርጓሚ እንዲቀርብልዎ ከረዳሉ በጤ ፕላን መታወቂያዎት ላይ በለውበተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711 |
| 7 | 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 |
| 8 | 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 |
| 9 | 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. |

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| 10 | 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 |
| 11 | Tagalog | May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711 |
| 12 | 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。 |
| 13 | Cushite | Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirgani qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711 |
| 14 | Persian | 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 |
| 15 | Kru | 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 |
| 16 | Ibo | Inwere ikike inweta enyemaka nakwa įmųta asųsų gi n'efu n'akwughį ųgwọ. Maka įkpọturų onye nsųgharį okwu, kpọọ akara ekwentį nke dij nąkwųkwọ njirimara gi nke emere maka ahųike gi, pja 0. TTY 711. |
| 17 | Yoruba | O ní ẹtọ lati rí iranwọ àti ifitónilétí gbà ní èdè rẹ láisanwó. Látí bá ògbufo kan sọrọ, pè sóri nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711 |

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

If you think you were treated unfairly 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 member toll-free phone number listed on your ID card.

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
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