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 1-866-673-6293. 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.

1-000-407-2303 to request a copy.				
Important Questions	Answers	Why This Matters:		
What is the overall deductible?	Network: \$2,800 Individual / \$5,600 Family out-of-Network: \$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> is 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/.</u>		
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?	Network: \$5,500 Individual / \$11,000 Family out-of-Network: \$15,000 Individual / \$30,000 Family	The <u>out-of-pocket</u> <u>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</u> <u>limits</u> until the overall family <u>out-of-pocket</u> <u>limit</u> has been met.		
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.		
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider Network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's Network</u> . You will pay the most if you use an <u>out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's 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-Network 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 specialist you choose without a referral.		

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common	Comisso Vou Mou Nood	What You Will Pay			
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% <u>coinsurance</u>	Virtual visits (Telehealth) - 20% <u>coinsurance</u> by a Designated Virtual <u>Network Provider</u> . No virtual coverage for out-of-Network.	
	Specialist visit	20% coinsurance	50% coinsurance	None	
	Preventive care/screening/immunization	No Charge	* Not Covered	*Certain services are covered when using an out-of-Network. Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% coinsurance	<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% coinsurance	50% <u>coinsurance</u>	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.	

Common Medical Event	Carvings Vou May Nood	What You Will Pay			
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need drugs to treat your illness or	Tier 1 - Your Lowest-Cost Option	Retail: \$15 <u>copay</u> Mail-Order: \$37.50 <u>copay</u>	Retail: \$15 copay	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	
condition More information about prescription	Tier 2 - Your Midrange-Cost Option	Retail: \$45 copay Mail-Order: \$112.50 copay	Retail: \$45 copay	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	
drug coverage is available at www. welcometouhc.com.	Tier 3 - Your Midrange-Cost Option	Retail: \$90 copay Mail-Order: \$225 copay	Retail: \$90 copay	above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.	
	Tier 4 - Additional High-Cost Options	Retail: \$350 copay Mail-Order: \$875 copay	Retail: \$350 copay	Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable <u>copay</u> and/or <u>coinsurance</u> may be applied. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	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	None	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
	<u>Urgent care</u>	20% coinsurance	50% coinsurance	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.	

Common What You Will Pay		u Will Pay		
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Network partial hospitalization /intensive outpatient treatment: 20% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to 50% of allowed.
	Inpatient services	20% coinsurance	50% <u>coinsurance</u>	Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	50% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient <u>preauthorization</u> apply for out-of-Network 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	Home health care	20% coinsurance	50% coinsurance	Limited to 364 visits per calendar year. Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cardiac & Pulmonary Unlimited.
	Habilitation services	20% coinsurance	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit to 50% of allowed.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled nursing is limited to 100 days per calendar year . Preauthorization required for out-of-Network or benefit reduces to 50% of allowed.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over \$1,000 or no coverage.

Common			ı Will Pay	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required for out-of-Network 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	No Charge	50% <u>coinsurance</u>	One exam every 12 months.
	Children's glasses	20% coinsurance	50% coinsurance	One pair every 12 months.
	Children's dental check-up	0% coinsurance	50% <u>coinsurance</u>	Cleanings covered 2 times per 12 months.

Excluded Services & Other Covered Services:

Services Your Plan Geneservices.)	erally Does NOT Cover (Check	k your policy or <u>plan</u> documen	t for more information and a	list of any other excluded
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 <u>plan</u> document.)

• Bariatric Surgery

• Spinal Manipulations-20 visits per calendar year

Hearing Aids

- Infertility Treatment artificial insemination only
- Private Duty Nursing Inpatient only
- Routine eye care (Adult)-1 exam/12 months
- 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 1-866-673-6293. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: 1-866-673-6293; 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-673-6293.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293. Chinese (中文): 如果需要中文的帮助,**请拨打这个号码** 1-866-673-6293. Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-866-673-6293.

-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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)

■ The plan's overall deductible	\$ 2,800
Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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)

T-4-1 E--- 1- C--4

Total Example Cost	\$12,800		
In this example, Peg would pay:			
Cost Sharing			
Deductibles	\$2,800		
Copayments	\$30		
Coinsurance	\$1,700		
What isn't covered			
Limits or exclusions \$60			
The total Peg would pay is	\$4,590		

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$ 2,800
Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Total Example Cost

Prescription drugs

#12 OOO

Durable medical equipment (glucose meter)

φ/, 4 00			
In this example, Joe would pay:			
\$2,800			
\$800			
\$70			
What isn't covered			
\$30			
\$3,700			

Mia's Simple Fracture

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

■ The plan's overall deductible	\$ 2,800
Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)

Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost

\$7.400

In this example, Mia would pay:		
Cost Sharing		
Deductibles	\$1,900	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,900	

\$1,900

Appendix A Colorado Supplement to the Summary of Benefits and Coverage Form

	INSURANCE COMPANY NAME	UnitedHealthcare Insurance Company
	NAME OF PLAN	Choice Plus BP77 /831
1.	Type of Policy	Small Employer Group Policy
2.	Type of Plan	Point of service (POS)
2.	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

<u>Important Note:</u> 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
10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
11. 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)

Emal: insurance@dora.state.co.us

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-6293

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-673-6293

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-866-673-6293

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. TTY711

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 ТТҮ 711
6	Amharic	ያለ ምንምክፍያ በቋንቋዎ እርዳታና ሙረጃ የ ማፃኘት ሙብት አላቸሁ።
		አስተርዓሚእንዲቀርብልዎከፈለን በጤና ፕላን ሙታወቂያዎት ላይ
		ባለውበተጻ ሙስლር ስልክ ቁጥር ይደውሉና 0 ን ይጭታ። TTY 711
7	Arabic	لك الحق في الحصول على المساعدة و المعلومات 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)
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.

10	Monal:	
10	Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग
		छ। अनुवादक प्राप्त गरीपाऊँ 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―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 mirga
		ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa
		eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tugi. 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 imuta asusu gi n'efu n'akwughi
		ugwo. Maka ikpoturu onye nsughari okwu, kpoo akara ekwenti nke di
		nákwukwo njirimara gi nke emere maka ahuike gi, pia 0. TTY 711.
17	Yoruba	O ní eto lati rí iranwo àti ìfitónilétí gbà ní èdè re láìsanwó. Láti bá ògbufo
		kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi
		idánimo ti ètò ilera re, te '0'. TTY 711
17	Yoruba	nákwukwo njirimara gi nke emere maka ahuike gi, pia 0. TTY 711. O ní eto lati rí iranwo àti ìfitónilétí gbà ní èdè re láìsanwó. Láti bá ògl kan soro, pè sórí nombà ero ibánisoro láisanwó ibodè ti a tò sóri kád

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