UnitedHealthcare®

Benefit Summary

Platinum 90 PPO-1
California - Select Plus
Traditional - Plan AV68

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Select Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$15	You have no individual deductible.	10%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	You do not have to pay a medical deductible.	$1,000 per year
Medical Deductible - Family	You do not have to pay a medical deductible.	$2,000 per year
Dental - Pediatric Services Deductible - Individual	You do not have to pay a dental deductible.	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	You do not have to pay a dental deductible.	Included in your medical deductible.
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$3,350 per year	$8,000 per year
Out-of-Pocket Limit - Family	$6,700 per year	$16,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance	$150 co-pay per transport. A deductible does not apply.	$150 co-pay per transport. A deductible does not apply.
Non-Emergency Ambulance	$150 co-pay per transport. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is recommended for Non-Emergency Ambulance.	Prior Authorization is recommended for Non-Emergency Ambulance.
Breast Cancer Services		
	The amount you pay is based on where the covered health care service is provided.	
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is recommended.	Prior Authorization is recommended.
Congenital Heart Disease Surgeries		
	Benefits will be the same as stated under Hospital - Inpatient Stay.	Out-of-Network Benefits are not available.
Dental Anesthesia Services		
Limited to Covered Persons who are one of the following: a child under seven years of age; a person who is developmentally disabled regardless of age; or a person whose health is compromised and for whom general anesthesia is required, regardless of age.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is recommended.	Prior Authorization is recommended.
Dental - Pediatric Services (Benefits covered up to age 19)		
Benefits provided by the National Options PPO 30 Network (PPO-UCR 50th).		

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 time every 6 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Fluoride Treatments Limited to 1 time every 6 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Space Maintainers (Spacers) Limited to once per quadrant per lifetime.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Dental - Pediatric Diagnostic Services		
Evaluations (Check-up Exams) 1 time every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.
Intraoral Radiographs (X-ray) Limited to 1 series of films every 6 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing. A deductible does not apply.	20% co-insurance. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Basic Dental Services		
Endodontics (Root Canal Therapy)	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite) Multiple restorations on one surface will be treated as a single filling and limited to 1 per tooth per 12 months.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental - Pediatric Major Restorative Services		
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months after 12 months from initial insertion.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
	Prior Authorization is recommended for orthodontic treatment.	Prior Authorization is recommended for orthodontic treatment.
Dental Services - Accident Only		
	10% co-insurance. A deductible does not apply.	10% co-insurance. A deductible does not apply.
	Prior Authorization is recommended.	Prior Authorization is recommended.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
		Prior Authorization is recommended for Durable Medical Equipment that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Diabetes Treatment		
Coverage for diabetes equipment and supplies, prescription items and diabetes self-management training programs when provided by or under the direction of a Physician.	The amount you pay is based on where the covered health care service is provided. Benefits for diabetes supplies will be the same as those stated in section 12 of the COC.	
Durable Medical Equipment (DME), Orthotics and Supplies		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for Durable Medical Equipment that costs more than $1,000.
Emergency Health Care Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply for Facility Fee. You pay nothing for Physician Fee. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply for Facility Fee. You pay nothing for Physician Fee. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Enteral Formula and Amino Acid-Modified Food Products (Medical Foods)		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is recommended for certain services.	Prior Authorization is recommended for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient:	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies are limited per year as follows: 24 visits of Manipulative Treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of pervasive developmental disorder or Autism Spectrum Disorders.	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for certain services.
Hearing Aids		
Limited to $2,500 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. This limit does not apply to bone-anchored hearing aids.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
Benefits are limited as follows: Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health care aide. Up to three visits per day (counting all home health care visits). Up to 100 visits per calendar year (counting all home health care visits other than for rehabilitative or habilitative care). Up to 100 visits per calendar year (counting all home health care visits) for habilitative care. Up to 100 visits per calendar year (counting all home health care visits) for rehabilitative care. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.
Hospice Care		
	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for Inpatient Stay.
Hospital - Inpatient Stay		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Infertility Services		
Limited to $2,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Schedule of Benefits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician's Office Services.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	$15 co-pay per service. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	$30 co-pay per service. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for certain services.
Major Diagnostic and Imaging - Outpatient		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.
Mastectomy Services		
	The amount you pay is based on where the covered health care service is provided.	
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Outpatient Office Visits:	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
All Other Outpatient Treatment:	You pay nothing. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Nicotine Use Benefit		
Benefits for nicotine use medications are provided under the Outpatient Prescription Drug Schedule of Benefits. Tobacco use and tobacco-related disease counseling and interventions and medications required to be provided under the Preventive Care Services benefit by the Patient Protection and Affordable Care Act are not subject to any cost sharing when provided by Network providers.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Obesity - Weight Loss Surgery		
Obesity surgery is covered when received at a designated facility and performed by a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is recommended.	Out-of-Network Benefits are not available.
Off-Label Drug Use and Experimental or Investigational Services		
	The amount you pay is based on where the covered health care service is provided.	
Orthotic Benefit		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for Orthotic Devices that costs more than $1,000.
Osteoporosis Services		
	The amount you pay is based on where the covered health care service is provided.	
Ostomy and Urological Supplies		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Phenylketonuria (PKU) Treatment		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended.
Physician Fees for Surgical and Medical Services		
	10% co-insurance for outpatient. A deductible does not apply. 10% co-insurance for inpatient. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services		
	$15 co-pay per visit for a primary care physician office visit. A deductible does not apply. $30 co-pay per visit for a specialist office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
We pay for Covered Health Services incurred if you participate in the California Prenatal Screening Program, a statewide prenatal testing program administered by the State Department of Health Services. There is no cost share for this Benefit.	Hospital - Inpatient Stay: 10% co-insurance. A deductible does not apply. Physician Fees for Surgical and Medical Services: 10% co-insurance. A deductible does not apply. Prenatal Care and Preconception Physician Office Visit: You pay nothing. A deductible does not apply. First Postnatal/Postpartum Physician Office Visit: You pay nothing. A deductible does not apply. Subsequent Postnatal/Postpartum Physician Office Visit: The amount you pay is based on where the covered health care service is provided.	10% co-insurance. A deductible does not apply. Prior Authorization is recommended if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for Prosthetic Devices that costs more than $1,000.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is recommended for certain services.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 24 visits of Manipulative Treatments. Visit limits are not applied to occupational therapy, physical therapy or speech therapy for the Medically Necessary treatment of a health condition, including pervasive developmental disorder or Autism Spectrum Disorders.	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is recommended for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay)		
Limited to 100 days per benefit period for Skilled Nursing Facility. Inpatient rehabilitation facility services are unlimited. Inpatient habilitative services are unlimited.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is recommended.
Specialized Footwear		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is recommended for specialized footwear that costs more than $1,000
Surgery - Outpatient		
	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is recommended for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Telehealth Services		
	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is recommended for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is recommended for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$15 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Routine Vision Exam Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing. A deductible does not apply.	You pay nothing. A deductible does not apply.
Eyeglass Frames Limited to once every 12 months.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/ or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Low Vision Services		
Low Vision Comprehensive Evaluation Limited to once every 24 months.	You pay nothing for Low Vision Comprehensive Evaluation. A deductible does not apply.	25% co-insurance for Low Vision Comprehensive Evaluation. A deductible does not apply.
Low Vision Follow-up Care Limited to four visits in any 5 year period.	You pay nothing for Low Vision Follow-up Care. A deductible does not apply.	25% co-insurance for Low Vision Follow-up Care. A deductible does not apply.
Low vision aid such as high-power spectacles, magnifiers and telescopes. Limited to once every 12 months.	10% co-insurncae for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.	25% co-insurance for Low Vision aid such as high-power spectacles, magnifiers and telescopes. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Vision Examination (Benefit is for Covered Persons over age 19)		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every calendar year. Limited to 2 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aniridia. Limited to 6 contact lenses per eye (including fitting and dispensing) per 12-month period to treat aphakia. This Benefit is limited to adults (age 19 and older). Benefits for routine vision examinations for Covered Persons under age 19 are provided as described in the Pediatric Vision Care Services.	$15 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; aromatherapy; hypnotism; massage therapy (this exclusion does not apply to Covered Health Care Services provided for therapy services that are part of a physical therapy treatment plan for which Benefits are provided as described under Home Health Care, Hospice Care, Rehabilitation Services - Outpatient Therapy and Manipulative Treatment or Habilitative Services - Outpatient Therapy and Manipulative Treatment in Section 1 of the COC); rolfing; adventure-based therapy, wilderness therapy, outdoor therapy or similar programs, art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to general anesthesia and associated Hospital or Alternate Facility charges for which Benefits are provided as described under Dental Anesthesia Services in Section 1 of the COC. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of an acute traumatic health condition, cancer or cleft palate. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, except as provided under Dental Services - Accident Only and Preventive Care Services in Section 1 of the COC. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). This exclusion does not apply to orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth. This exclusion does not apply to dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures as described under Reconstructive Procedures in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Any Dental Procedure not performed in a dental setting. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Denials of coverage are subject to Independent Medical Review for Experimental and Investigational Therapies. Dispensing of drugs/medications not normally supplied in a dental office. Replacement of loss or theft of dentures or bridgework. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Certificate. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Dental implants are excluded, but it is considered optional dental treatment. An optional benefit is a dental benefit that you choose to have upgraded. For example when a filling would correct the tooth but you choose to have a full crown instead. If you choose to have an implant rather than a Covered Dental Service such as a denture or fixed bridge, we will pay our cost share of the Covered Dental Service and you will be responsible for the additional cost of the upgrade to a dental implant. Orthodontic treatment unless medically necessary as described under Medically Necessary Orthodontic Services in Section 10 of the COC. Surgical removal of impacted teeth is Covered Dental Service only when evidence of pathology exists.

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to help in communication and speech except for prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC and speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Services your plan does not cover (Exclusions)

Drugs

Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1of the COC. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1of the COC. Growth hormone therapy, except when Medically Necessary. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product, except as Medically Necessary. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product unless Medically Necessary. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us or when Medically Necessary. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded except Benefits provided for clinical trials for cancer and for Experimental or Investigational Services and Unproven Services as defined under Section 9: Defined Terms in the COC and except that coverage which is provided for an FDA-approved drug prescribed for a use that is different from the use for which the FDA approved it, when needed for treatment of a long term and seriously debilitating or Life-Threatening condition. The drug must appear on the formulary list, if applicable. The drug must be recognized for treatment of the condition for which the drug is being prescribed by any of the following: (1) the American Hospital Formulary Service's Drug Information; (2) one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: Elsevier Gold Standard's Clinical Pharmacology, National Comprehensive Cancer Network Drug and Biologics Compendium, or Thomson Micromedex DrugDex; or (3) it is recommended by two clinical studies or review articles in major peer reviewed professional journals. However, there is no coverage for any drug that the FDA or a major peer reviewed medical journal has determined to be contraindicated for the specific treatment for which the drug has been prescribed. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Shoes. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment and Specialized Footwear in Section 1of the COC. Shoe orthotics. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC. Shoe inserts. This exclusion does not apply to shoes for which Benefits are provided as described under Diabetes Treatment and Specialized Footwear in Section 1of the COC. Arch supports. This exclusion does not apply to shoes for which Benefits are provided as described under Specialized Footwear in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings. This exclusion does not apply to:

- Lymphedema gradient compression stockings for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC.
- Prosthetic devices incident to a laryngectomy for which Benefits are provided as described under Prosthetic Devices - Laryngectomy in Section 1 of the COC.
- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Treatment in Section 1 of the COC.
- Ostomy and urological supplies for which Benefits are provided as described under Ostomy and Urological Supplies in Section 1 of the COC.

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

Nutrition

Enteral feedings, even if the sole source of nutrition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers (this exclusion does not apply to batteries for home blood glucose monitors and infusion pumps as described under Diabetes Treatment and Durable Medical Equipment in Section 1 of the COC); breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement and as required by California regulation); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs (for example, Weight Watchers®, Jenny Craig® or other structured weight loss programs) whether or not they are under medical supervision. This exclusion does not apply to the surgical or non-surgical treatment of morbid obesity for which Benefits are provided as described under Obesity Surgery in Section 1 of the COC. This exclusion does not apply to services that have in effect the current recommendations of the United States Preventive Services Task Force for obesity screening in children, adolescents and all adults as described under Preventive Care Services in Section 1: of the COC. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Psychosurgery. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations; and physical therapy modalities that have general value but show limited or no efficacy in the treatment of TMJ including cold laser, diathermy, thermography, iontophoresis, biofeedback, and TENS. Upper and lower jawbone surgery except as required for direct treatment of an acute traumatic health condition, dislocation, tumors or cancer or as described in Temporomandibular Joint (TMJ) Services under Section 1 of the COC, orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to health education counseling programs and materials, including programs for tobacco cessation, as described under Other Health Education Services for You in the section of the Certificate titled Our Responsibilities. This exclusion does not apply to counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under Preventive Care Services in Section 1of the COC. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Obesity - weight loss surgery not received at a Designated Provider.

Services your plan does not cover (Exclusions)

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal address. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider has not been involved in your medical care prior to ordering the service, or is not involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

The following infertility treatment-related services: Cryo-preservation and other forms of preservation of reproductive materials. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. Donor services. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. The reversal of voluntary sterilization. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

Transplants

Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s Benefits under the Policy.) Health care services for transplants involving permanent mechanical or animal organs.

Travel

Health care services provided in a foreign country, unless required as Emergency Health Care Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. This exclusion does not apply to Medically Necessary pain management for acute and chronic pain provided during an Inpatient Stay in a Hospital. Custodial care or maintenance care. This exclusion does not apply to Custodial Care or maintenance care for which Benefits are provided under Home Health Care, Hospice Care, Hospital - Inpatient Stay, Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Including Habilitative Services During an Inpatient Stay), Habilitative Services - Outpatient Therapy and Rehabilitative Services - Outpatient Therapy and Manipulative Treatment in Section 1 of the COC. Domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. This exclusion does not apply to services for which Benefits are provided under Hospice Care and Home Health Care in Section 1 of the COC. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to special contact lenses for aniridia and aphakia for which Benefits are provided as described under Vision Examinations in Section 1 of the COC. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). This exclusion does not apply to contact lenses for aniridia (missing iris) and aphakia (absence of crystalline lens of the eye). Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when the Covered Person has either of the following: Craniofacial anomalies in which normal or absent ear canals prevent the use of a wearable hearing aid; or Hearing loss of sufficient severity that it cannot be remedied enough by a wearable hearing aid. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services.

All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which are all of the following: Medically Necessary. Not otherwise excluded in Section 2 of the COC. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian Injured or otherwise affected by war, any act of war, or terrorism in the United States or in non-war zones outside of the United States. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other dollar amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible are waived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage of body fluids, body tissues or body parts. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or Out-of-Network provider. This exclusion does not apply to interpretive services available in UnitedHealthcare's language assistance program as required by California law. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

For Internal Use only:
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UnitedHealthcare Insurance 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 Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

California Plan 354

Standard Drugs: 5/15/25/10%

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Out-of-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Ancillary Charges.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate of Coverage, the Certificate of Coverage shall prevail.

UnitedHealthcare Insurance Company

Tier Level	Up to 31-day supply			Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	****Retail Non-Preferred Specialty Network Pharmacy**	**Retail Out-of-Network Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	**$5**	**$10**	**$5**	**$12.50**
Tier 2 Prescription Drug Products	**$15**	**$30**	**$15**	**$37.50**
Tier 3 Prescription Drug Products	**$25**	**$50**	**$25**	**$62.50**
Tier 4 Prescription Drug Products	**10% however you will not pay more than $250**	**10% however you will not pay more than $500**	**10% however you will not pay more than $250**	**10% however you will not pay more than $625**

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

** For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Schedule of Benefits or Pharmaceutical Products for which Benefits are described in your Certificate are subject to step therapy requirements. Step therapy is a process whereby Prescription Drug Products or Pharmaceutical Products are filled with an effective, but more affordable medication. When appropriate, a more costly medication can be authorized if the Prescription Drug Product or Pharmaceutical Product is not effective in treating the Covered Person's condition. Step therapy is designed to encourage the use of cost-effective Prescription Drug Products or Pharmaceutical Products when appropriate. If the Covered Person's Physician determines that a Prescription Drug Product is or Pharmaceutical Product subject to the step therapy requirements is not medically appropriate or is not satisfactorily treating the Covered Person's condition, the Physician can request an exception to the step therapy process by contacting us at www.unitedhealthcareonline.com. If the Covered Person is changing policies, we will not require the Covered Person to repeat step therapy when the Covered Person is already being treated for a medical condition by a Prescription Drug Product provided the Prescription Drug Product is appropriately prescribed and considered safe and effective for the Covered Person's medical condition. However, we may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy requirements imposed by the former policy. The prescribing provider may also prescribe another Prescription Drug Product covered under this Policy that is medically appropriate for the Covered Person's medical condition. You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the internet at www.myuhc.com® or by calling the telephone number on your ID card. A request for an exception to the step therapy requirements may be submitted in the same manner as a request for prior authorization for Prescription Drug Products as described in Prior Authorization Requirements of this Outpatient Prescription Drug Schedule of Benefits.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com® or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you may be subject to the Out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com® or the telephone number on your ID card.

Other Important Information about your Outpatient Prescription Drug Benefits

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply to these services. In addition see your COC and SBN for additional exclusions and limitations that may apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay (Benefits for Prescription Drug Products provided during an Inpatient Stay are available as described under Hospital - Inpatient Stay in Section 1of your COC).
- Experimental, Investigational or Unproven Services and medications; medications used for Experimental indications and/or dosage regimens that are Experimental, Investigational or Unproven.
- Prescription Drug Products provided by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Any product dispensed for the purpose of appetite suppression or weight loss when prescribed solely for the purposes of losing weight. This exclusion does not apply to outpatient prescription drugs prescribed for the Medically Necessary treatment of morbid obesity for which Benefits are provided as described under Obesity - Weight Loss Surgery in Section 1of the COC.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided as described Durable Medical Equipment and Diabetes Treatment in Section 1of your COC. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins. This exclusion does not apply to vitamins that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) that are required to be covered under the Patient Protection and Affordable Care Act (PPACA).
- Unit dose packaging or repackagers of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Service unless Medically Necessary.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 4.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. However, this exclusion does not apply to coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter. Certain Prescription Drug Products that are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by California law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1of the COC. This exclusion also does not apply to over-the-counter aids and/or drugs used for smoking cessation, or over-the-counter medications that have an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF) when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Any oral non-sedating antihistamine or antihistamine-decongestant combination.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease and prescription medical food products, even when used for the treatment of a health condition, except as described under Enteral Formula and Amino Acid-Modified Food Products and Phenylketonuria (PKU) Treatment in Section 1 of the COC.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals. This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in Section 10 Pediatric Dental Services of the COC.
- A Prescription Drug Product with either an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product unless Medically Necessary. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following: it is highly similar to a reference product (a biological Prescription Drug Product) and it has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

UnitedHealthcare Insurance 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 Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

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

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.