UnitedHealthcare®

Benefit Summary

Navigate Gold 1000
Colorado - Navigate
Navigate Direct - Plan ATNO

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 UnitedHealthcare Navigate® Direct Plan?

Get a plan with a Primary Care Provider (PCP) to help coordinate your care.

This is a health plan that requires you to select a PCP who can help guide you through the health care system so you can get the right care at the right time.

> **Select your personal PCP from the plan network.** Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care. You need to get online referrals from your PCP to see a network specialist.

> **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.

> **There's no coverage if you go out of the network.** You will be responsible for the entire cost of the service.

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

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.

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.

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)
$20	$1,000	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 of Colorado, Inc.

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

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.

> This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	$1,000 per year
Medical Deductible - Family	$2,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	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, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$5,000 per year
Out-of-Pocket Limit - Family	$10,000 per year

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.

An access plan describing how we monitor the Network of providers is available by calling us at the number on your ID card. The access plan also has information on complaint procedures, quality programs and Benefits for Emergency Health Services.

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
Ambulance Services	
Emergency Ambulance	10% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance	10% co-insurance, after the medical deductible has been met.
Bariatric 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.
Cleft Lip and Cleft Palate Treatment	
	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.
Congenital Heart Disease Surgeries	
	Benefits will be the same as stated under Hospital - Inpatient Stay.
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Diagnostic Services	
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	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.	40% co-insurance, after the medical deductible has been met.
Oral Surgery	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.	40% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	40% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	40% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	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, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	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, after the medical deductible has been met.
Dental Services - Accident Only	
	10% co-insurance, after the medical deductible has been met.
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 Benefit.
Durable Medical Equipment (DME), Orthotics and Supplies	
	10% co-insurance, after the medical deductible has been met.
Emergency Health Care Services - Outpatient	
	10% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Gender Dysphoria	
	The amount you pay is based on where the covered health care service is provided.
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: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive therapy. 20 visits of Manipulative Treatments.	$40 co-pay per visit for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply. $20 co-pay per visit for all other rehabilitation services. A deductible does not apply.
Hearing Aids	
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.	10% co-insurance, after the medical deductible has been met.
Home Health Care	
Limited to 364 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Home Health Special Services Program - Limited to 15 visits per lifetime. This does not count toward the 364 visits limit above.	10% co-insurance, after the medical deductible has been met.
Hospice Care	
	10% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Hospital - Inpatient Stay	
This Benefit includes Private Duty Nursing provided on an inpatient basis only when skilled nursing care is not available from the Hospital, or as determined to be Medically Necessary.	After you pay the $500 per occurrence deductible per Inpatient Stay; you pay 10% co-insurance, after the medical deductible has been met for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician.
Hospitalization and General Anesthesia for Dental Procedures for Children	
	The amount you pay is based on where the covered health care service is provided.
Infertility Services	
For Network Benefits, infertility services must be received at a Designated Facility and performed by a Designated Physician.	10% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife.
Lab, X-Ray and Diagnostic - Outpatient	
Lab Testing - Outpatient	You pay nothing for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office. A deductible does not apply.
X-Ray and Other Diagnostic Testing - Outpatient	You pay nothing for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office. A deductible does not apply.
Major Diagnostic and Imaging - Outpatient	
	10% co-insurance, after the medical deductible has been met for services provided at a freestanding diagnostic center or in a physician's office. After you pay the $500 per occurrence deductible per service; you pay 10% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.
Mental Health Care and Substance - Related and Addictive Disorders Services	
Inpatient:	10% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.
Ostomy Supplies	
Limited to $2,500 per year.	10% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met.
Phenylketonuria (PKU) Testing and Treatment	
	The amount you pay is based on where the covered health care service is provided.
Physician Fees for Surgical and Medical Services	
	10% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician.
Physician's Office Services - Sickness and Injury	
	$20 co-pay per visit for services provided by your Primary Care Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. A deductible does not apply. $40 co-pay per visit for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.

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

Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Prescription Drug Benefits	

Prescription drug benefits are shown in the Prescription Drug benefit summary.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Preventive Care Services	
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist, or advanced practice nurse who is a certified nurse midwife. A deductible does not apply. You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.
Additional Preventive Care Services. All FDA approved methods of contraception are covered under this Policy without cost sharing as required by federal and state law.	You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. A deductible does not apply. You pay nothing for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply.
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, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health care service is provided.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Limited to: 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments.	$40 co-pay per visit for manipulative treatment services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply. $20 co-pay per visit for all other rehabilitation services. A deductible does not apply.

Covered Health Care Services	Your cost if you use Network Benefits
Rehabilitation Services - Outpatient Therapy for Congenital Defect and Birth Abnormalities	
Limited to care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered up to 20 visits each for physical, occupational and speech therapy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity. This limit of 20 visits for each therapy to treat congenital defects and birth abnormalities does not apply to therapy that is Medically Necessary to treat Autism Spectrum Disorders.	$20 co-pay per visit. A deductible does not apply.
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office provided by your Primary Care Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met for services provided at a freestanding center or in a physician's office for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. After you pay the $500 per occurrence deductible per date of service; you pay 10% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center provided by your Primary Care Physician or Network Obstetrician or gynecologist. After you pay the $500 per occurrence deductible per date of service; you pay 10% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 100 days per year in a Skilled Nursing Facility.	10% co-insurance, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Surgery - Outpatient	
	10% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office provided by your Primary Care Physician or Network Obstetrician or gynecologist or advanced practice nurse who is a certified nurse midwife. 10% co-insurance, after the medical deductible has been met for services provided at an ambulatory surgical center or in a physician's office for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. After you pay the $500 per occurrence deductible per date of service; you pay 10% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center provided by your Primary Care Physician or Network Obstetrician or gynecologist. After you pay the $500 per occurrence deductible per date of service; you pay 10% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician.
Telehealth Services	
	The amount you pay is based on where the covered health care service is provided.
Temporomandibular Joint Services	
	The amount you pay is based on where the covered health care service is provided.
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, after the medical deductible has been met.
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.
Urgent Care Center Services	
	$20 co-pay per visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.

Covered Health Care Services	Your cost if you use Network Benefits
Virtual Visits	
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.	You pay nothing. A deductible does not apply.

Covered Health Care Services	Your cost if you use 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.	$10 co-pay per visit. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	$25 co-pay. 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.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	You pay nothing. A deductible does not apply.
Eyeglass frames with a retail cost between $130 - 160.	$15 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost between $160 - 200.	$30 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost between $200 - 250.	$50 co-pay. A deductible does not apply.
Eyeglass frames with a retail cost greater than $250.	40% 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.	$25 co-pay. A deductible does not apply.
Low Vision Care Services Limited to once every 24 months.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.
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 12 months.	$10 co-pay per visit. A deductible does not apply.

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; acupuncture; aromatherapy; hypnotism; massage therapy; 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 7 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 accident-related dental services, pediatric dental services, treatment of cleft lip or cleft palate, or dental related hospitalization and general anesthesia for children for which Benefits are provided as described under Dental Services - Accident Only, Pediatric Dental Services, Cleft Lip and Cleft Palate Treatment, and Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 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 acute traumatic Injury, 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. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion does not apply to accident-related dental services, pediatric dental services, treatment of cleft lip or cleft palate, or dental related hospitalization and general anesthesia for children for which Benefits are provided as described under Dental Services - Accident Only, Pediatric Dental Services, Cleft Lip and Cleft Palate Treatment, and Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services, pediatric dental services, treatment of cleft lip or cleft palate, or dental related hospitalization and general anesthesia for children for which Benefits are provided as described under Dental Services - Accident Only, Pediatric Dental Services, Cleft Lip and Cleft Palate Treatment, and Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 of the COC. This exclusion does not apply to pediatric dental services for which Benefits are described under Pediatric Dental Services in Section 7 of the COC. Dental braces (orthodontics). This exclusion does not apply to pediatric dental services or treatment of cleft lip or cleft palate for which Benefits are provided as described under Pediatric Dental Services and Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to pediatric dental services or treatment of cleft lip or cleft palate for which Benefits are provided as described under Pediatric Dental Services and Cleft Lip and Cleft Palate Treatment in Section 7 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 in Pediatric Dental Services in Section 1 of the COC. Dental Services that are not Necessary. Hospitalization or other facility charges. This exclusion does not apply to hospitalization or facility charges for which Benefits are provided as described under Hospital - Inpatient Stay or Hospitalization and General Anesthesia for Dental Procedures for Children in Section 7 of the COC. Any Dental Procedure performed solely for cosmetic/ aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. This exclusion does not apply to reconstructive surgery or treatment of cleft lip or cleft palate for which Benefits are provided as described under Reconstructive Procedures or Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Any Dental Procedure not directly related with dental disease. 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. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit. This exclusion does not apply to drugs/ medications for which Benefits are provided as described under Outpatient Prescription Drugs in Section 7 of the COC. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. This exclusion does not apply to treatment for which Benefits are provided as described under Physician Fees for Surgical and Medical Services in Section 7 of the COC. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to treatment for which Benefits are provided as described under Physician Fees for Surgical and Medical Services or Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. This exclusion does not apply to TMJ related services for which Benefits are provided as described under Temporomandibular Joint Services (TMJ) in Section 7 of the COC. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Policy. 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. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child. Foreign Services are not covered unless required as an Emergency. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. This exclusion does not apply to prosthodontic restoration procedures for which Benefits are provided as described under Cleft Lip and Cleft Palate Treatment in Section 7 of the COC. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO). Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. This exclusion does not apply to treatment of the temporomandibular joint for which Benefits are provided as described under Temporomandibular Joint Services (TMJ) in Section 7 of the COC. Dental Services received from an out-of-Network Dental Provider.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. The following devices are excluded, even if prescribed by a Physician: corrective shoes and orthotic devices for podiatric use and arch supports; dental devices and appliances except as described under Temporomandibular Joint Services (TMJ) and Cleft Lip and Cleft Palate Treatment in Section 7 of the COC; experimental and research braces; more than one orthotic device for the same part of the body, except for replacements; spare devices or alternate use devices; replacement of lost braces or orthotic devices; and repairs, adjustments or replacements of braces and orthotic devices necessitated by misuse. 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 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 7 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.

Drugs

Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. 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. Such determinations may be made up to six times during a calendar year. 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. 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. 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. Such determinations may be made up to six times during a calendar year. These above exclusions do not apply to drugs or medications, Pharmaceutical Products or forms for which Benefits are provided as described under Outpatient Prescription Drugs in Section 7 of the COC.

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. 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. This exclusion does not apply to a prescribed drug if: the drug has been approved by the Food and Drug Administration (FDA) as an "investigational new drug for treatment use"; if it is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; the drug has been approved by the FDA for the treatment of cancer but has not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: the drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services, and the treatment is for a Covered Health Service. 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 7 of the COC.

Services your plan does not cover (Exclusions)

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 7 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. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics (this exclusion does not apply to orthotics for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 7 of the COC); shoe inserts and arch supports.

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, urinary catheters. This exclusion does not apply to:

- 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 7 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 Services in Section 7 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 7 of the COC

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 7 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.

Services your plan does not cover (Exclusions)

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

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. This exclusion does not apply to Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders for which Benefits are provided as described under Phenylketonuria (PKU) Testing and Medical Foods in Section 7of the COC. 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.

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; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); 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 15 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 7 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 whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Services your plan does not cover (Exclusions)

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. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This exclusion does not apply to services and treatment for which Benefits are provided as described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, Cleft Lip and Cleft Palate Treatment, and Rehabilitation Services - Outpatient Therapies for Congenital Defects and Birth Abnormalities in Section 7 of the COC. Rehabilitation services for speech therapy as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. This exclusion does not apply to speech therapy for which Benefits are provided as described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, Cleft Lip and Cleft Palate Treatment, and Rehabilitation Services - Outpatient Therapies for Congenital Defects and Birth Abnormalities in Section 7 of the COC. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke. 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; and dental restorations. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Non-surgical treatment of obesity. 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. 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 7 of the COC.

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

All services and supplies related to conception by artificial means except Artificial Insemination for which Benefits are described under Infertility Services in Section 7 of the COC. This exclusion includes but is not limited to the following services and any prescription drugs, donor semen and donor eggs related to such services: in vitro fertilization, regardless of the reason for treatment; ovum transplants; gamete intra fallopian transfer; and zygote intra fallopian transfer. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. This exclusion does not apply when the Covered Person is the surrogate for which Benefits are available as described under Pregnancy - Maternity Services in Section 7 of the COC. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services your plan does not cover (Exclusions)

Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners. 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 for organ and tissue transplants, except those described under Transplantation Services in Section 7 of the COC. 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. Transplant services that are not performed at a Designated Provider. This exclusion does not apply to cornea transplants.

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 as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 7of 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. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. This exclusion does not apply to Private Duty Nursing for which Benefits are provided as described under Hospital - Inpatient Stay in Section 7 of the COC. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 7 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to the following: Pediatric vision care services for which Benefits are provided as described in Pediatric Vision Care Services in Section 7 of the COC; Professional exams and fitting of Medically Necessary contact lenses when a Network Physician or Network Optometrist prescribes them for a specific medical condition. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. 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 either of the following applies: You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid. You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. 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 Routine Vision Examination and Pediatric Vision Services in Section 7 of the COC for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are provided as described under Physician Fees for Surgical and Medical Services in Section 7 of the COC.

Services your plan does not cover (Exclusions)

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 under Vision Care Services in Section 7 of the COC. Missed appointment charges. Applicable sales tax charged on Vision Care Services. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.

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 we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 7 of the COC and Schedule of Benefits; and not otherwise excluded in Section 8 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption (this exclusion does not apply to treatment for Injuries resulting from a Covered Person's casual or nonprofessional participation in motorcycling, snowmobiling, off-highway vehicle riding, skiing or snowboarding); related to judicial or administrative proceedings or orders, except for Medically Necessary Mental Health Care Services and Substance-Related and Addictive Disorders Services regardless of whether the services are voluntary or court-ordered as a result of contact with the criminal justice or juvenile justice system, that we determine meet the definition of a Covered Health Care Service and for which Benefits are otherwise covered under the Policy as described under Mental Health Care and Substance-Related and Addictive Disorders Services in Section 7 of the COC; Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 7 of the COC); required to get or maintain a license of any type. 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 non-war zones. 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 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. 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. 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:
COWAX51ATNO18

Item#	Rev. Date	
380-9696	0917	Gated POST/Sep/Emb/31392/2018

UnitedHealthcare of Colorado, Inc. 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.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Colorado Plan 252

Standard Drugs: 15/35/70/250

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	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit	
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.

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 Outpatient Prescription Drug Benefit and 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 Outpatient Prescription Drug Benefit or the Certificate of Coverage, the Outpatient Prescription Drug Benefit and Certificate of Coverage shall prevail.

UnitedHealthcare of Colorado, Inc.

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**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	**$15**	**$30**	**$37.50**
Tier 2 Prescription Drug Products	**$35**	**$70**	**$87.50**
Tier 3 Prescription Drug Products	**$70**	**$140**	**$175**
Tier 4 Prescription Drug Products	**$250**	**$500**	**$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

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 Benefit are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com® or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require prior authorization to be obtained 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, no Benefits will be paid 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.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com® or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, no Benefits will be paid for that Prescription Drug Product after the allowed number of fills at Retail 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.

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. In addition see your Pharmacy Benefit 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.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during and Inpatient Stay. This exclusion does not apply to drugs for which Benefits are provided as described under Hospital - Inpatient Stay in Section 7of the COC.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This does not include Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA) for use in the treatment of cancer but have not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: The drug is recognized for treatment of that cancer in the authoritative reference compendia as indicated by the secretary of the U.S. Department of Health and Human Services; and the treatment is for a Covered Health Service.
- Prescription Drug Products furnished 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.
- Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. This exclusion does not apply to Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided as described under Pharmaceutical Products - Outpatient in Section 7 of the COC. 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 under Durable Medical Equipment (DME), Orthotics and Supplies in Section 7 of the 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.
- 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 we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products for which Benefits are provided as described under Infertility Services in Section 7 of the COC.
- Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.
- 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. Certain Prescription Drug Products that we have determined 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 prescribed over-the-counter FDA-approved contraceptives, over-the-counter aids and/or drugs used for tobacco 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 provided as described under Preventive Care Services in Section 7 of the COC.
- Certain new Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.

- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- 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 Sickness or Injury, except for Medical Foods prescribed for the treatment of Inherited Enzymatic Disorders for which Benefits are provided as described under Phenylketonuria (PKU) Testing and Medical Foods in Section 7 of the COC.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug 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.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug 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.
- 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.
- Certain Prescription Drug Products that have not been prescribed by a Specialist.
- Outpatient Prescription Drug Products obtained from an Out-of-Network Pharmacy.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.
- A Prescription Drug Product with either an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. 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.
- Treatment for toenail Onychomycosis (toenail fungus).

UnitedHealthcare of Colorado, Inc. 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 ដែលមានចែងលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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.

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