**UnitedHealthcare of Illinois, Inc.**
200 E. Randolph Street / Suite 5300 / Chicago, IL 60601

# Benefit Summary

Charter Gold 0
Illinois - Charter
Charter - Plan AUHG

## 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 Charter 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.**

> **There's no coverage if you go out of network or if you see a network specialist without a referral.** You will be responsible for the entire cost of the service.

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

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/charter** 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) |
|---|---|---|
| $35 | You have no individual deductible. | 20% |

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 Illinois, 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.

| | |
|---|---|
| Medical Deductible - Individual | You do not have to pay a medical deductible. |
| Medical Deductible - Family | You do not have to pay a medical deductible. |
| Dental - Pediatric Services Deductible - Individual | You do not have to pay a dental deductible. |
| Dental - Pediatric Services Deductible - Family | You do not have to pay a dental 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 and co-insurance (including pharmacy) count towards meeting the out-of-pocket limit.

| | |
|---|---|
| Out-of-Pocket Limit - Individual | $6,900 per year |
| Out-of-Pocket Limit - Family | $13,800 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.

## 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 | 20% co-insurance. A deductible does not apply. |
| Non-Emergency Ambulance | 20% co-insurance. A deductible does not apply.<br>Prior Authorization is required for Non-Emergency Ambulance. |
| **Amino Acid-Based Elemental Formulas** | |
| Diagnosis and Treatment | The amount you pay is based on where the covered health care service is provided. |
| Amino acid-based formulas for the treatment of eosinophilic disorders and short bowel syndrome. | 20% co-insurance. A deductible does not apply or as stated under the Outpatient Prescription Drug Schedule of Benefits.<br>Prior Authorization is required for certain services. |
| **Clinical Trials (including Cancer Clinical Trials)** | |
| | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required, except for routine patient care costs associated with cancer clinical trials. |
| **Congenital Heart Disease (CHD) 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)**<br>Limited to two times every 12 months. | You pay nothing. A deductible does not apply. |
| **Fluoride Treatments**<br>Limited to two times every 12 months. | You pay nothing. A deductible does not apply. |
| **Sealants (Protective Coating)**<br>Limited to once per first or second permanent molar every 36 months. | You pay nothing. A deductible does not apply. |
| **Space Maintainers (Spacers)** | You pay nothing. A deductible does not apply. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Dental - Pediatric Diagnostic Services** | |
| **Evaluations (Check-up Exams)**<br>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. A deductible does not apply. |
| **Intraoral Radiographs (X-ray)**<br>Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image. | You pay nothing. A deductible does not apply. |
| **Dental - Pediatric Basic Dental Services** | |
| **Endodontics (Root Canal Therapy)** | 20% co-insurance. A deductible does not apply. |
| **Adjunctive Services**<br>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.<br>General Anesthesia: Covered only when clinically Necessary.<br>Occlusal Guard: Limited to one guard every 12 months. | 20% co-insurance. A deductible does not apply. |
| **Oral Surgery** | 20% co-insurance. A deductible does not apply. |
| **Periodontics**<br>Periodontal Surgery: Limited to one every 36 months per surgical area.<br>Scaling and Root Planing: Limited to one time per quadrant every 24 months.<br>Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis. | 20% co-insurance. A deductible does not apply. |
| **Minor Restorative Services (Amalgam or Anterior Composite)** | 20% co-insurance. A deductible does not apply. |
| **Simple Extractions (Simple tooth removal)**<br>Limited to one time per tooth per lifetime. | 20% co-insurance. A deductible does not apply. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Dental - Pediatric Major Restorative Services** | |
| **Crowns/Inlays/Onlays**<br>Limited to one time per tooth every 60 months. | 50% co-insurance. A deductible does not apply. |
| **Removable Dentures**<br>(Full denture/partial denture)<br>Limited to a frequency of one every 60 months. | 50% co-insurance. A deductible does not apply. |
| **Bridges (Fixed partial dentures)**<br>Limited to one time every 60 months. | 50% co-insurance. A deductible does not apply. |
| **Implant Procedures**<br>Limited to one time every 60 months. | 50% co-insurance. A deductible does not apply. |
| **Dental - Pediatric Medically Necessary Orthodontics** | |
| Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies. | 50% co-insurance. A deductible does not apply.<br><br>Prior Authorization is required for orthodontic treatment. |
| **Dental Services - Accident Only** | |
| | 20% co-insurance. A deductible does not apply.<br><br>Prior Authorization is required. |
| **Dental Services - Anesthesia and Facility** | |
| | The amount you pay is based on where the covered health care service is provided.<br><br>Prior Authorization is required for certain services. |
| **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 Schedule of Benefits. |
| **Durable Medical Equipment (DME), Orthotics and Supplies** | |
| | 20% co-insurance. A deductible does not apply. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Emergency Health Care Services - Outpatient** | |
| | 20% co-insurance after you pay the $400 co-pay per visit. A deductible does not apply.<br>Notification is required if confined in an Out-of-Network Hospital. |
| **Examination and Treatment for Sexual Assault** | |
| | You pay nothing. A deductible does not apply. |
| **Gender Dysphoria** | |
| | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required for certain services. |
| **Habilitative Services** | |
| Inpatient: | The amount you pay is based on where the covered health care service is provided. |
| Outpatient: | $70 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.<br>$35 co-pay per visit for all other rehabilitation services. A deductible does not apply. |
| **Hearing Aids** | |
| Limited to two hearing aids every 36 months. | 20% co-insurance. A deductible does not apply. |
| **Home Health Care** | |
| | 20% co-insurance. A deductible does not apply. |
| **Hospice Care** | |
| | 20% co-insurance. A deductible does not apply. |
| **Hospital - Inpatient Stay** | |
| | 20% co-insurance for services provided with a referral to the admitting Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Infertility Services** | |
| Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per lifetime; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered for a maximum of six oocyte retrievals per lifetime. Following the final oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person. | 20% co-insurance (with a referral from your Primary Physician or when services are provided by an obstetrician or gynecologist). A deductible does not apply.<br>20% co-insurance (by a Physician other than an obstetrician or gynecologist without a referral from your Primary Physician). A deductible does not apply.<br><br>Prior Authorization is required. |
| **Lab, X-Ray and Diagnostic - Outpatient** | |
| Lab Testing - Outpatient | 20% co-insurance. A deductible does not apply. |
| X-Ray and Other Diagnostic Testing - Outpatient | 20% co-insurance. A deductible does not apply. |
| **Major Diagnostic and Imaging - Outpatient** | |
| | $400 co-pay per service. A deductible does not apply. |
| **Mental Health Care and Substance Use Disorders Services** | |
| Inpatient: | 20% co-insurance. A deductible does not apply. |
| Outpatient: | $35 co-pay per visit. A deductible does not apply. |
| Partial Hospitalization/Intensive Outpatient Treatment: | 20% co-insurance. A deductible does not apply. |
| **Naprapathic Services** | |
| Limited to 15 visits per year. | $35 co-pay per visit for for services provided by your Primary Care Physician. A deductible does not apply.<br>$70 co-pay per visit with a referral for services provided from your Primary Care Physician. A deductible does not apply. |

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Obesity - Weight Loss Surgery** | |
| For designated network benefits, obesity surgery must be received at a designated facility and performed by a designated physician. Network benefits include services received at a network facility that is not a designated facility and performed by a network physician that is not a designated physician. Designated services are provided by Bariatric Resource Services, a program for surgical weight loss solutions. | 30% co-insurance. A deductible does not apply.<br><br>Prior Authorization is required. |
| **Ostomy Supplies** | |
| Limited to $2,500 per year. | 20% co-insurance. A deductible does not apply. |
| **Pharmaceutical Products - Outpatient** | |
| This includes medications given at a doctor's office, or in a Covered Person's home. | 20% co-insurance. A deductible does not apply. |
| **Physician Fees for Surgical and Medical Services** | |
| | 20% co-insurance for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br>20% co-insurance for services provided by a Network Specialist or other Network Physician with a referral from your Primary Care Physician. A deductible does not apply. |
| **Physician's Office Services - Sickness and Injury** | |
| | Covered persons less than age 19:<br>You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br>All other Covered Persons:<br>$35 co-pay per visit for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br><br>$70 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 and lab work.

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Pregnancy - Maternity Services** | |
| Note: We will waive the annual deductible or co-payment on the newborn's fees during the time the mother and baby are in the hospital together. This waiver applies to the baby's eligible inpatient claims including, but not limited to, physician fees and facility fees. However, if baby stays longer than the mother, the baby's annual deductible will apply upon mother's discharge from the hospital. If the baby's birth mother is not covered under the policy, the baby's annual deductible is not waived. | The amount you pay is based on where the covered health care service is provided. |
| **Prescription Drug Benefits** | |
| Prescription drug benefits are shown in the Prescription Drug benefit summary. | |
| **Preventive Care Services** | |
| Physician Office Services, Lab, X-Ray or other preventive tests. | You pay nothing for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br>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. | |
| **Private Duty Nursing** | |
| | 20% co-insurance. A deductible does not apply.<br>Prior Authorization is required. |
| **Prosthetic Devices** | |
| | 20% co-insurance. A deductible does not apply. |
| **Reconstructive Procedures** | |
| | The amount you pay is based on where the covered health care service is provided. |

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment** | |
| | $70 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.<br>$35 co-pay per visit for all other rehabilitation services. 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. | 20% co-insurance for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br>20% co-insurance for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply. |
| **Skilled Nursing Facility / Inpatient Rehabilitation Facility Services** | |
| | 20% co-insurance. A deductible does not apply. |
| **Surgery - Outpatient** | |
| | 20% co-insurance for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply.<br>20% co-insurance for services provided with a referral to the servicing Network Specialist or other Network Physician from your Primary Care Physician. A deductible does not apply. |
| **Temporomandibular Joint Services and Craniomandibular Disorder** | |
| | 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. | 20% co-insurance. A deductible does not apply. |
| **Transplantation Services** | |
| Network Benefits must be received at a designated facility. | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Urgent Care Center Services** | |
| | $50 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 and lab work. | |
| **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. | $10 co-pay per visit. 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**<br>Limited to once every 12 months. | You pay nothing. A deductible does not apply. |
| **Eyeglass Lenses**<br>Limited to once every 12 months. | You pay nothing. A deductible does not apply. |
| **Lens Extras**<br>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**<br>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. | You pay nothing. A deductible does not apply. |
| Eyeglass frames with a retail cost between $160 - 200. | You pay nothing. A deductible does not apply. |
| Eyeglass frames with a retail cost between $200 - 250. | You pay nothing. A deductible does not apply. |
| Eyeglass frames with a retail cost greater than $250. | You pay nothing. A deductible does not apply. |
| **Contact Lenses/Necessary Contact Lenses**<br>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.<br>Fitting and evaluation limited to once every 12 months.<br>Limited to a 12 month supply.<br>Find a complete list of covered contacts at myuhcvision.com. | You pay nothing. A deductible does not apply. |
| **Low Vision Care Services**<br>Limited to once every 24 months. | You pay nothing for Low Vision Testing. A deductible does not apply.<br>25% co-insurance for Low Vision Therapy. 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; aromatherapy; hypnotism; massage therapy (excluded when services are not provided by a covered provider); 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, or treatment for Autism Spectrum Disorders for which Benefits are provided as described in Section 1 of the COC.

### Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental anesthesia and associated hospital or alternate facility charges as described under Dental - Anesthesia and Facility in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral bacterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance) 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 (this exclusion does not apply to the surgical removal of complete bony impacted 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 also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

## Services your plan does not cover (Exclusions)

### Dental - Pediatric Services

Benefits are not provided under Pediatric Dental Services for the following: Any Dental Service or Procedure not listed as a Covered Pediatric Dental Service. Dental Services that are not Necessary. Hospitalization or other facility charges. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.) 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. 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. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. 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. 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. 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 this 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. 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. Partial dentures are covered only for recipients with good health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected. 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. Benefits for space maintainers are provided in this section under the Preventive Services provision in Benefits for Covered Dental Services. Benefits for TMJ and any surgical procedures to correct a malocclusion are considered medical in nature and, depending upon where the Covered Health Care Services are provided, are described under the applicable Benefit category in Section 1 of the COC and in the Medical Schedule of Benefits. Dental Services received from an out-of-Network Dental Provider.

### Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Cranial banding, unless Medically Necessary. 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 1 of the COC. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

## Services your plan does not cover (Exclusions)

### Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their traits, 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. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices and products as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC. 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.

### 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 Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

### Foot Care

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

## Services your plan does not cover (Exclusions)

### 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 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC

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

### Mental Health Care and Substance Use 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 or under IL law 215 ILCS 5/370c. 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 or under IL law 215 ILCS 5/370c. 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. This exclusion does not apply to services for Autism Spectrum Disorders for Covered Persons for which Benefits are provided as described under Section 1 of the COC. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to services for Autism Spectrum Disorders for Covered Persons for which Benefits are provided as described under Section 1 of the COC. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Transitional Living services.

### Nutrition

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 amino acid-based elemental formulas or 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. 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.

## Services your plan does not cover (Exclusions)

### Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs 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.

### 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. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. 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. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature, except those described under Temporomandibular Joint Services in Section 1 of the COC. 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. Surgical and non-surgical treatment of obesity, except those described under Obesity Surgery in Section 1 of the COC. Stand-alone multi-disciplinary tobacco cessation programs, except for those described under Preventive Care Services in Section 1 of the COC. 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 1 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.

## Services your plan does not cover (Exclusions)

### Reproduction

The reversal of voluntary sterilization; however, in the event a voluntary sterilization is successfully reversed, Infertility benefits shall be available if the Covered Person's diagnosis meets the definition of Infertility. Payment for services rendered to a surrogate (however, costs for procedures to obtain eggs, sperm or embryos from a Covered Person will be covered if the individual chooses to use a surrogate). Costs associated with cryo preservation and storage of sperm, eggs, and embryos; provided, however, subsequent procedures of a medical nature necessary to make use of the cryo preserved substance shall not be similarly excluded if deemed non-experimental and non-investigational. Selected termination of an embryo; provided, however, that where the life of the mother would be in danger were all embryos to be carried to full term, the termination would be covered. Non-medical costs of an egg or sperm donor. Travel costs for travel within 100 miles of the Covered Person's home address, travel costs not necessary, not mandated or required by us. Infertility treatments deemed experimental in nature. However, where Infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature shall be covered. Infertility treatments rendered to dependents under the age of 18.

### 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. 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 1 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 reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

### Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing, except as described under Private Duty Nursing in Section 1 of the COC. Exclusions include: Inpatient Private Duty Nursing; services provided to a Covered Person by an Independent nurse who is hired directy by the Covered Person or his/her family (this includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing); services for the comfort or convenience of the Covered Person or the Covered Person's caregiver; services that are custodial in nature (Custodial Care); and Intermittent care. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

## Services your plan does not cover (Exclusions)

### Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. 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. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions. Routine vision exams, including refractive exams to determine the need for vision correction.

### Vision - Pediatric Services

Benefits are not provided under Pediatric Vision Services for the following: Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the COC. Non-prescription items (e.g. Plano lenses). Replacement or repair of lenses and/or frames that have been lost or broken. Optional Lens Extras not listed in Vision Care Services. Missed appointment charges. Applicable sales tax charged on Vision Care Services. 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 are determined to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 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, Civil Union or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). 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 1 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. 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 baterial infections - except infections which result from accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance, following a Cosmetic Procedure, that require hospitalization. Services for the treatment of Autism Spectrum Disorders provided by or required by law to be provided by a school, municipality or other state or federal agency.

**For Internal Use only:**
**ILWAN16AUHG18**

| Item# | Rev. Date | |
|---|---|---|
| 230-15439 | 1017_rev01 | Gated/Sep/Emb/31119/2018 |

UnitedHealthcare of Illinois, 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.

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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.