UnitedHealthcare®

Benefit Summary

Navigate Balanced Gold 2000
Arizona - Navigate Balanced
Navigate Balanced Direct - Plan BJD3

What is a benefit summary?

This is only 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® Balanced 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 get the highest coverage when your PCP submits an online referral for you to see a network specialist. But, referrals are not required.

> **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	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$35	$2,000	20%

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UnitedHealthcare of Arizona, 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	$2,000 per year
Medical Deductible - Family	$4,000 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	$6,000 per year
Out-of-Pocket Limit - Family	$12,000 per year

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Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

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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	
Benefits are provided for emergency ambulance services, without prior authorization, to the nearest hospital or other facility that is licensed or otherwise authorized to furnish emergency health care services. Non-emergency ambulance services between facilities only when the transport meets certain criteria.	
Emergency Ambulance:	20% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Cellular and Gene Therapy	
Benefits are provided for Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury. Prior Authorization is required.
Clinical Trials	
Benefits are provided for routine patient care costs incurred while taking part in a qualifying clinical trial.	
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
Benefits are provided for CHD surgeries which are ordered by a physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta and aortic stenosis.	
	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.

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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.

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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. Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only	
Benefits are provided for dental treatment if needed because of accidental damage, when you receive dental services from a Doctor of Dental Surgery, Doctor of Medical Dentistry or Physician.	20% co-insurance, after the medical deductible has been met.
Dental Services - Hospital or Alternative Facility/Anesthesia	
Benefits are provided for general anesthesia and associated hospital or alternative facility charges in connection with dental services for oral surgery when your underlying medical condition requires general anesthesia to be rendered in a hospital or alternative facility setting.	20% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Diabetes Services	
Benefits are provided for diabetes services, including but not limited to outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits for diabetic supplies are described under the Outpatient Prescription Drug Rider.	
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. Benefits will be the same as those stated under Physician Office Services - Sickness and Injury.
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 and in the Outpatient Prescription Drug Rider.

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Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Durable Medical Equipment (DME), Orthotics and Supplies	
Benefits are provided for durable medical equipment and certain orthotics and supplies.	20% co-insurance, after the medical deductible has been met.
Emergency Health Care Services - Outpatient	
Benefits are provided for a screening examination and services that are required to stabilize or begin treatment in an emergency including the assessment and stabilization of a psychiatric emergency medical condition.	20% co-insurance, after the medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria	
Benefits are provided for the treatment of gender dysphoria provided by or under the direction of a physician.	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider. Benefits will be the same as those stated under Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures. Prior Authorization is required for certain services.
Habilitative Services	
Benefits are provided for habilitative services and devices that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. Devices means benefits for DME and prosthetic devices, when used as part of habilitative services, as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices.	
Inpatient:	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.
Outpatient: Outpatient therapies are limited per year as follows: 60 combined visits per year of physical therapy, occupational therapy, and/or speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive therapy.	$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. $70 co-pay per visit for manipulative treatment services provided without a referral from your Primary Care Physician. A deductible does not apply. $35 co-pay per visit for all habilitative services. A deductible does not apply.

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Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Hearing Aids	
Benefits are provided for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).	
Limited to a single purchase per hearing impaired ear every year. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20% co-insurance, after the medical deductible has been met.
Home Health Care	
Benefits are provided for services, including Habilitative and Rehabilitative Services, received from a home health agency.	
Limited to 60 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 Agency services that are provided in lieu of an Inpatient Stay are not subject to this limit. For the administration of intravenous infusion, you must receive services from a provider we identify.	20% co-insurance, after the medical deductible has been met.
Hospice Care	
Benefits are provided for hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care services include inpatient care, outpatient services, professional services of a physician, services of a psychologist, social worker or family counselor for individual and family counseling, and home health services.	
	20% co-insurance, after the medical deductible has been met.
Hospital - Inpatient Stay	
Benefits are provided for services and supplies provided during an inpatient stay in a hospital, including physician services for radiologists, anesthesiologists, pathologists and emergency room physicians. Benefits for other physician services are described under Physician Fees for Surgical and Medical Services.	
	20% 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. 20% co-insurance, after the medical deductible has been met for services provided without a referral from your Primary Care Physician.

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Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Lab, X-Ray and Diagnostic - Outpatient	
Benefits are provided for services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office, including physician services for radiologists, anesthesiologists and pathologists. Benefits for other physician services are described under Physician Fees for Surgical and Medical Services.	
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. You pay nothing for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. 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. You pay nothing for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. A deductible does not apply.
Major Diagnostic and Imaging - Outpatient	
Benefits are provided for CT scans, PET scans, MRI, MRA, Brain Electrical Activity Mapping (BEAM), Electroconvulsive therapy (ECT), nuclear medicine and major diagnostic services received on an outpatient basis at a hospital or alternate facility or in a physician's office.	
	20% 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 $250 per occurrence deductible per service; you pay 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.
Manipulative Treatment	
Benefits are provided for manipulative treatment when performed by a physician or licensed chiropractic provider.	
Limited to: 20 visits of Manipulative Treatments.	$70 co-pay per visit. A deductible does not apply.
Mental Health Care and Substance - Related and Addictive Disorders Services	
Benefits are provided for mental health care and substance-related and addictive disorders services, including those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office.	
Inpatient:	20% co-insurance, after the medical deductible has been met.
Outpatient:	$35 co-pay per visit. A deductible does not apply.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.

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Covered Health Care Services	Your cost if you use Network Benefits

Obesity - Weight Loss Surgery

Benefits for obesity - weight loss surgery are provided for certain services and available only when certain criteria are met. Covered procedures and criteria that must be met are described under Obesity - Weight Loss Surgery in Section 1 of the COC.

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.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Off-Label Drugs for the Treatment of Cancer

Benefits are available for drugs prescribed for the treatment of cancer if the drug has been recognized by the Food and Drug Administration as safe and effective for treatment of that specific type of cancer in one or more of the acceptable standard medical reference compendia or medical literature.

The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Pharmaceutical Products - Outpatient and Physician Office Services - Sickness and Injury or as described under the Outpatient Prescription Drug Schedule of Benefits.

Orthognathic Surgery

Benefits are provided for orthognathic treatment and surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) when determined to be medically necessary.

The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury; Surgery - Outpatient; and Temporomandibular Joint (TMJ) Services.

Ostomy Supplies

Benefits are provided for ostomy supplies when determined medically appropriate.

20% co-insurance, after the medical deductible has been met.

Pharmaceutical Products - Outpatient

Benefits are provided for pharmaceutical products for services administered on an outpatient basis in a hospital, alternate facility, physician's office, or in your home.

This includes medications given at a doctor’s office, or in a Covered Person’s home.	20% co-insurance, after the medical deductible has been met.

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Covered Health Care Services	Your cost if you use Network Benefits
Physician Fees for Surgical and Medical Services	
Benefits are provided for physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility, or for physician house calls.	
	20% co-insurance, after the medical deductible has been met for services provided by your Primary Care Physician, Network obstetrician or gynecologist. 20% 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. 20% co-insurance, after the medical deductible has been met for services provided without a referral from your Primary Care Physician.
Physician's Office Services - Sickness and Injury	
Benefits are provided for services provided in a physician's office for the diagnosis and treatment of a sickness or injury.	
	$35 co-pay per visit for services provided by your Primary Care Physician, Network obstetrician or gynecologist. A deductible does not apply. $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. $70 co-pay per visit for services provided without 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	
Benefits are provided for pregnancy including all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.	
The coverage for birth costs for an adopted child under this Policy is secondary to any coverage for maternity-related expenses that the birth-mother may have and Benefits will be coordinated as described in Section 7 of the COC.	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. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Benefits are provided for preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital.	
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. 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.	

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Covered Health Care Services	Your cost if you use Network Benefits

Prosthetic Devices

Benefits are provided for external prosthetic devices that replace a limb or a body part and are necessary for the alleviation or correction of illness, injury, congenital defect or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns.

Limited to one wig or hairpiece per year when the Covered Person has alopecia as a result of chemotherapy, radiation therapy, second or third degree burns.	20% co-insurance, after the medical deductible has been met.

Reconstructive Procedures

Benefits are provided for reconstructive procedures when the primary purpose is to treat a medical condition or improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are related to an injury, sickness or congenital anomaly.

	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Prosthetic Devices.

Rehabilitation Services - Outpatient Therapy

Benefits are provided for rehabilitation services that are part of a prescribed treatment plan to help a person with a disabling condition to regain a skill or function required for functioning for daily living that has been acquired but lost due to illness, injury or disabling condition.

Limited to: 60 combined visits per year of physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy and/or cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy.	$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. $70 co-pay per visit for manipulative treatment services provided without a referral from your Primary Care Physician. A deductible does not apply. $35 co-pay per visit for all rehabilitation services. A deductible does not apply.

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Covered Health Care Services	Your cost if you use Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Benefits are provided for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a hospital or alternate facility or in a physician's office.	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% 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. 20% 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. 20% 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 without a referral from your Primary Care Physician. 20% 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. 20% 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. 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center for services provided without a referral from your Primary Care Physician.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Benefits are provided for services and supplies provided during an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility.	
Limited to 90 days per year. This limit does not apply to Inpatient Rehabilitation Facility services.	20% co-insurance, after the medical deductible has been met.

This Benefit Summary should only be used to highlight your Benefits. Don't use this document to understand your exact coverage, exclusions, and limitations. 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 covered, those which are excluded or limited, and other terms and conditions of coverage.

Covered Health Care Services	Your cost if you use Network Benefits
Surgery - Outpatient	
Benefits are provided for surgery and related services received on an outpatient basis at a hospital or alternate facility or in a physician's office.	
	20% 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. 20% 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. 20% 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 without a referral from your Primary Care Physician. After you pay the $250 per occurrence deductible per date of service; you pay 20% 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 $250 per occurrence deductible per date of service; you pay 20% 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. After you pay the $250 per occurrence deductible per date of service; you pay 20% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center for services provided without a referral from your Primary Care Physician.
Telemedicine	
Benefits are provided for health care services received through telemedicine if the health care service would be covered were it provided through in-person consultation between you and a health care provider and provided to you while receiving the covered health care service in the State of Arizona.	
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Lab, X-Ray and Diagnostics - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Office Services - Sickness and Injury or as described under the Outpatient Prescription Drug Schedule of Benefits.
Temporomandibular Joint Services	
Benefits are provided for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.	
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient.

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Covered Health Care Services	Your cost if you use Network Benefits
Therapeutic Treatments - Outpatient	
Benefits are provided for therapeutic treatments received on an outpatient basis at a hospital or alternate facility or in a physician's office.	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.
Transplantation Services	
Benefits are provided for organ and tissue transplants when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.	
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient. Prior Authorization is required.
Urgent Care Center Services	
Benefits are provided for services received at an urgent care center. When services to treat urgent health care needs are provided in a physician's office, Benefits are available as described under Physician's Office Services - Sickness and Injury.	
	$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.	
Virtual Visits	
Benefits are provided for virtual visits that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant physician or health specialist, through use of live audio and video technology outside of a medical facility.	
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.

This Benefit Summary should only be used to highlight your Benefits. Don't use this document to understand your exact coverage, exclusions, and limitations. 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 covered, those which are excluded or limited, and other terms and conditions of coverage.

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 per year.	You pay nothing. A deductible does not apply.
Eyeglass Lenses Limited to once per year.	You pay nothing. 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 per year.	You pay nothing. A deductible does not apply.
Contact Lens Fitting & Evaluation You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing. A deductible does not apply.
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 Exams (Benefit is for Covered Persons over age 19)	
Benefits are available for vision care services from a vision care provider. Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Limited to 1 exam every 12 months.	You pay nothing. A deductible does not apply.

This Benefit Summary should only be used to highlight your Benefits. Don't use this document to understand your exact coverage, exclusions, and limitations. 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 covered, those which are excluded or limited, and other terms and conditions of coverage.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

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

The following is a partial list of alternative treatments and therapies that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Acupressure, acupuncture, massage therapy and rolfing.
- Aromatherapy and Hypnotism.
- Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment.

Dental

The following is a partial list of dental supplies and services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Dental care, including dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia.
- 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.
- Endodontics, periodontal surgery and restorative treatment.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
- Dental implants, bone grafts and other implant-related procedures.
- 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) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Dental - Pediatric Services

The following is a list of pediatric dental supplies and services that are generally not covered. Review your Pediatric Dental Services Rider 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. Some exclusions do not apply, review Section 2: Exclusions and Limitations in your Rider to determine whether the exclusion applies or not.

- Any Dental Service or Procedure that is not listed as covered in Section 2: Benefits for Pediatric Dental Services in your Pediatric Dental Services Rider.
- Hospitalization or other facility charges.
- Any Dental Procedure performed solely for cosmetic/aesthetic reasons.
- Reconstructive surgery.
- Dental Procedures not directly related with dental disease.
- Dental Procedures not performed in a dental setting.
- Procedures that are considered to be Experimental or Investigational or Unproven Services.
- Drugs/medications, received with or without a prescription.
- Setting of facial bony fractures and any treatment related 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.
- Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through the Rider to 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.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 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 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.

Devices, Appliances and Prosthetics

The following is a partial list of devices, appliances and prosthetics that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Devices used as safety items or to help performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part.
- Cranial molding helmets and cranial banding except when required for surgery.
- Blood pressure cuff/monitor, enuresis alarm, non-wearable external defibrillator, trusses and ultrasonic nebulizers are not covered, even if prescribed by a Physician.
- Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1: Covered Health Care Services.
- 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.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered and non-powered exoskeleton devices.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Drugs

The following is a partial list of outpatient pharmaceutical products and services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Non-injectable medications given in a Physician's office, except as described in the Outpatient Prescription Drug Rider.
- Over-the-counter drugs and treatments.
- 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.
- Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

The following is a partial list of experimental or investigational and unproven services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

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.

Foot Care

The following is a partial list of foot care services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Routine foot care, examples include the cutting or removal of corns and calluses.
- Nail trimming, cutting, or debriding.
- Hygienic and preventive maintenance foot care.
- Treatment of subluxation of the foot.
- Shoes, shoe orthotics, shoe inserts and arch supports.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Gender Dysphoria

The following is a partial list of cosmetic procedures that are generally not covered. Review Section 2: Exclusions and Limitations in your COC for an exact description of the supplies and services that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Abdominoplasty and Blepharoplasty.
- Mastopexy, breast enlargement, including augmentation mammoplasty and breast implants.
- Liposuction and body contouring, such as lipoplasty.
- Calf, cheek, chin, and nose implants. Injection of fillers or neurotoxins.
- Brow, face and forehead lifts, or neck tightening.
- Rhinoplasty and facial bone remodeling for facial feminizations.
- Hair removal and hair transplantation.
- Lip augmentation and lip reduction.
- Pectoral implants for chest masculinization.
- 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

The following is a partial list of medical supplies and equipment that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Prescribed or non-prescribed medical supplies and disposable supplies.
- 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

The following is a partial list of mental health care and substance-related and addictive disorder services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Nutrition

The following is a partial list of nutrition supplies and services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences.
- Food of any kind including modified food products such as low protein and low carbohydrate; 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. See the Benefits for eosinophilic gastrointestinal disorder formula described under the Outpatient Prescription Drug Rider.

Personal Care, Comfort or Convenience

The following is a partial list of personal care, comfort or convenience items and services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Music devices, personal computers, radios, telephone, television and video players.
- Beauty/barber and guest service.
- Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.
- Batteries and battery chargers.
- Bath chairs, breast pumps, car seats, feeding chairs, strollers and toddler chairs.
- Chairs, Chair lifts, mattresses, motorized beds, pillows and recliners.
- Exercise equipment, treadmills.
- Home modifications such as elevators, handrails, ramps, stair lifts and stair glides.
- Jacuzzis, hot tubs, saunas and whirlpools.
- Medical alert systems and safety equipment.
- Power-operated vehicles and vehicle modifications such as van lifts.
- Hot and cold compresses.

Physical Appearance

The following is a partial list of cosmetic procedures that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Cosmetic Procedures are not covered, see definition under Section 9: Defined Terms in the COC. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures.
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin, including 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.
- 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.
- Wigs regardless of the reason for the hair loss, except as provided as described under Prosthetic Devices in Section 1: Covered Health Care Services.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Procedures and Treatments

The following is a partial list of procedures and treatments that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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.
- 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 or other medical or Mental Illness/ Substance-Related and Addictive Disorder Service.
- Outpatient cognitive rehabilitation therapy.
- 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, except when required for pain management performed in connection with Mental Health Care Services and Substance-Related and Addictive Disorder Services.
- Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment.
- Surgical and non-surgical treatment of obesity.
- Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998.
- Helicobacter pylori (H. pylori) serologic testing.
- Intracellular micronutrient testing.
- Health care services provided in the emergency department of Hospital or Alternate Facility that are not for an Emergency.

Providers

The following is a partial list of services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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.

Reproduction

The following is a partial list of reproduction services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Benefits for diagnostic testing for use in diagnosing infertility are covered the same as those for testing related to any other disease or condition.
- The following services related to a gestational carrier or surrogate:
  - Fees for the use of a gestational carrier or surrogate.
  - Pregnancy services for a gestational carrier or surrogate who is not a Covered Person.
  - Costs of donor eggs and donor sperm.
- Storage and retrieval of all reproductive materials.
- The reversal of voluntary sterilization.
- In vitro fertilization regardless of the reason for treatment.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Services Provided under Another Plan

The following is a partial list of services that are generally not covered, if coverage is provided under another plan. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation.
- 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, when you are on active duty for more than 30 days.

Transplants

The following is a partial list of transplants services and supplies that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1: Covered Health Care Services.
- 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 animal organs.

Travel

The following is a partial list of travel related services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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.
- Preauthorized covered health care services received from a Designated Provider that requires you to travel outside of the service area.

Types of Care

The following is a partial list of certain types of care that is generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
- Custodial care, maintenance care or domiciliary care.
- Private Duty Nursing or inpatient private room except when determined Medically Necessary.
- Respite care and rest cures.
- Services of personal care aides.
- Work hardening.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

Vision and Hearing

The following is a partial list of vision and hearing services and supplies that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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.
- 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

The following is a list of pediatric vision services and supplies that are generally not covered. Review your Pediatric Vision Care Services Rider for an exact description of the supplies and services that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- 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 Section 1 of the Rider: Benefits for Pediatric Vision Care Services.
- Missed appointment charges.
- Applicable sales tax charged on Vision Care Services.

Services your plan does not cover (Exclusions) - This is not a complete list of exclusions.

This is a partial list of services and supplies that your plan does not cover. Review Section 2: Exclusions and Limitations in your COC for an exact description of the services and supplies that are excluded or limited, and other terms and conditions of coverage. If this list of exclusions conflicts with the COC, the COC is correct.

All Other Exclusions

The following is a partial list of other services that are generally not covered. Some exclusion's do not apply, review Section 2: Exclusions and Limitations in your COC to determine whether the exclusion applies or not.

- 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 the COC under Section 1: Covered Health Care Services and in the Schedule of Benefits.
  - Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.
- 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.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to get or maintain a license of any type.
- Vaccinations and immunizations required as a prerequisite for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities unless such immunizations are also considered preventative care.
- 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.
- 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.

For Internal Use only:

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UnitedHealthcare of Arizona, 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.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल 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.