University of Miami Policy Brochure

Policy #2025-203591-1

1-833-931-0533

uhcsr.com/miami

United Healthcare | UNIVERSITY OF MIAMI

NOTE: UnitedHealthcare reserves the right to adjust the terms of the policy (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable state regulatory authority; and (iii) as otherwise permitted in the policy.
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Thanks for choosing UnitedHealthcare

This brochure highlights some of the features of the University of Miami Student Health Insurance Plan for Policy Number 2025-203591-1, which is underwritten by UnitedHealthcare Insurance Company. The Master Policy is on file with the Policyholder and contains the provisions, limitations, exclusions, and qualifications of the insurance benefits, some of which may not be included in this brochure. The Master Policy is the contract and will govern and control the payment of benefits. To download the University of Miami Student Health Certificate, please go to **uhcsr.com/miami**, which contains additional essential information about the policy along with a description of coverage, including benefits, exclusions, any reductions and limitations, and the terms under which the coverage may remain in force.

Student Health Service

The University of Miami Student Health Insurance Plan is designed to provide you with excellent care while keeping your out-of-pocket costs low. This plan works best when used alongside Student Health Services.

To get the most out of your benefits, start your care at Student Health Services where all medical services are covered 100%. Appointments can be scheduled at **MyUHealthChart.com**. Please visit **miami.edu/student-health** for further information.

After-Hours Care

Student Health Service also offers an after-hours line. You can reach the on-call provider at **1-305-284-9100**. For medical emergencies, when you're off-campus or when Student Health Service is closed, you can seek care from any doctor in the UnitedHealthcare Network by calling UnitedHealthcare Student Resources (UHCSR) Customer Service at **1-833-931-0533** or by visiting **uhcsr.com/miami** and simply clicking on "Find Medical Provider" and you'll be guided to enter our criteria to locate your preferred healthcare provider.

The Counseling Center

Counseling and mental health services, including psychiatric care, are provided by the **University of Miami Counseling Center**. The **initial step** for students seeking services is to have a brief assessment via an appointment or on a walk-in basis.

Need an appointment or more information? Please call **1-305-284-5511**.

Waiver/Opt Out

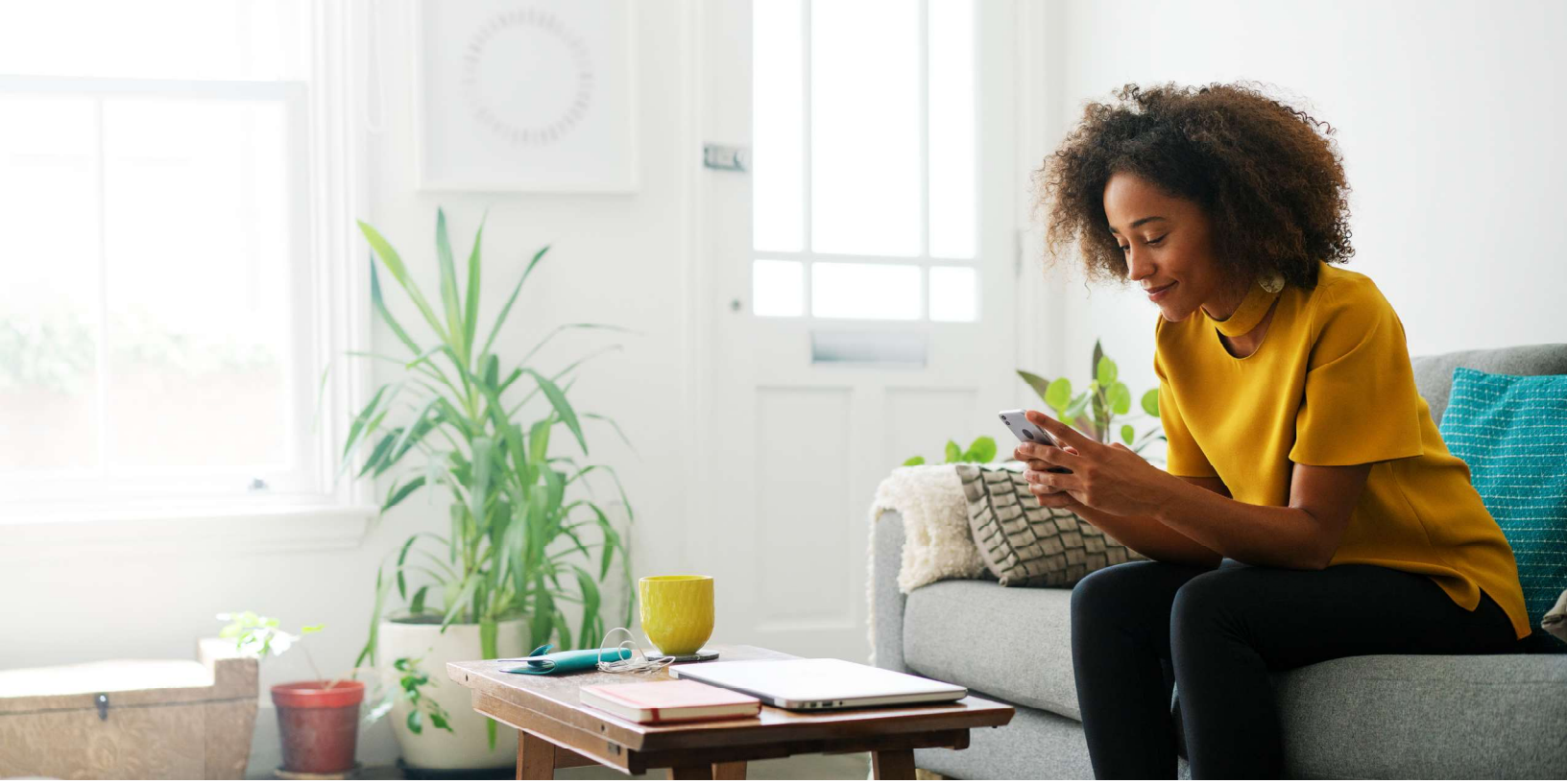
All Domestic undergraduate students actively enrolled in six or more credit hours and Domestic graduate students with full-time enrollment status per semester, will be charged the annual student health insurance unless proof of comparable coverage to waive this insurance requirement is submitted through the waiver portal. All International students regardless of credit hours, are required to be enrolled in the Student Health Insurance Plan unless Embassy sponsored. Eligible students are automatically charged the insurance premium along with their tuition fees.

For more information, please visit **miami.edu/student-health**.

How to get your insurance ID card

To download or print your insurance ID card, visit **uhcsr.com/miami** and sign in to your My Account.

You may also access your electronic ID card via the UHCSR mobile app, available on both Google Play and the Apple App. Store.



Coverage dates, rates and eligibility

Coverage for all insured students and eligible dependents will become effective at 12:01 a.m. on the Coverage Start Date indicated below and terminate at 11:59 p.m. on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Student coverage

Student Eligibility:

All Domestic undergraduate students actively enrolled in 6 or more credit hours per semester or considered full time (in a program requiring documentation of health insurance coverage), must purchase the student health insurance unless they show proof of comparable coverage to waive the insurance charge. All International students, regardless of credit hours, are required to be insured on the plan unless Embassy sponsored.

Students must actively attend classes for at least the first 31 days (unless an official medical withdrawal has been approved by the Student Health Service) after the date for which coverage is purchased. Non-degree seeking, non-credit courses, certificate programs, online or weekend only programs or courses do not fulfill the eligibility requirements.

Coverage period	Coverage start date	Coverage end date	Rates
Annual	8/15/2025	8/14/2026	$4,230
Fall	8/15/2025	1/4/2026	$1,699
Spring/Summer	1/5/2026	8/14/2026	$2,609
Summer	5/10/2026	8/14/2026	$1,169
Intl LLM	8/1/2025	6/30/2026	$4,022
Intl LLM Fall	8/1/2025	12/31/2025	$1,814
Intl LLM Spring	1/1/2026	6/30/2026	$2,137

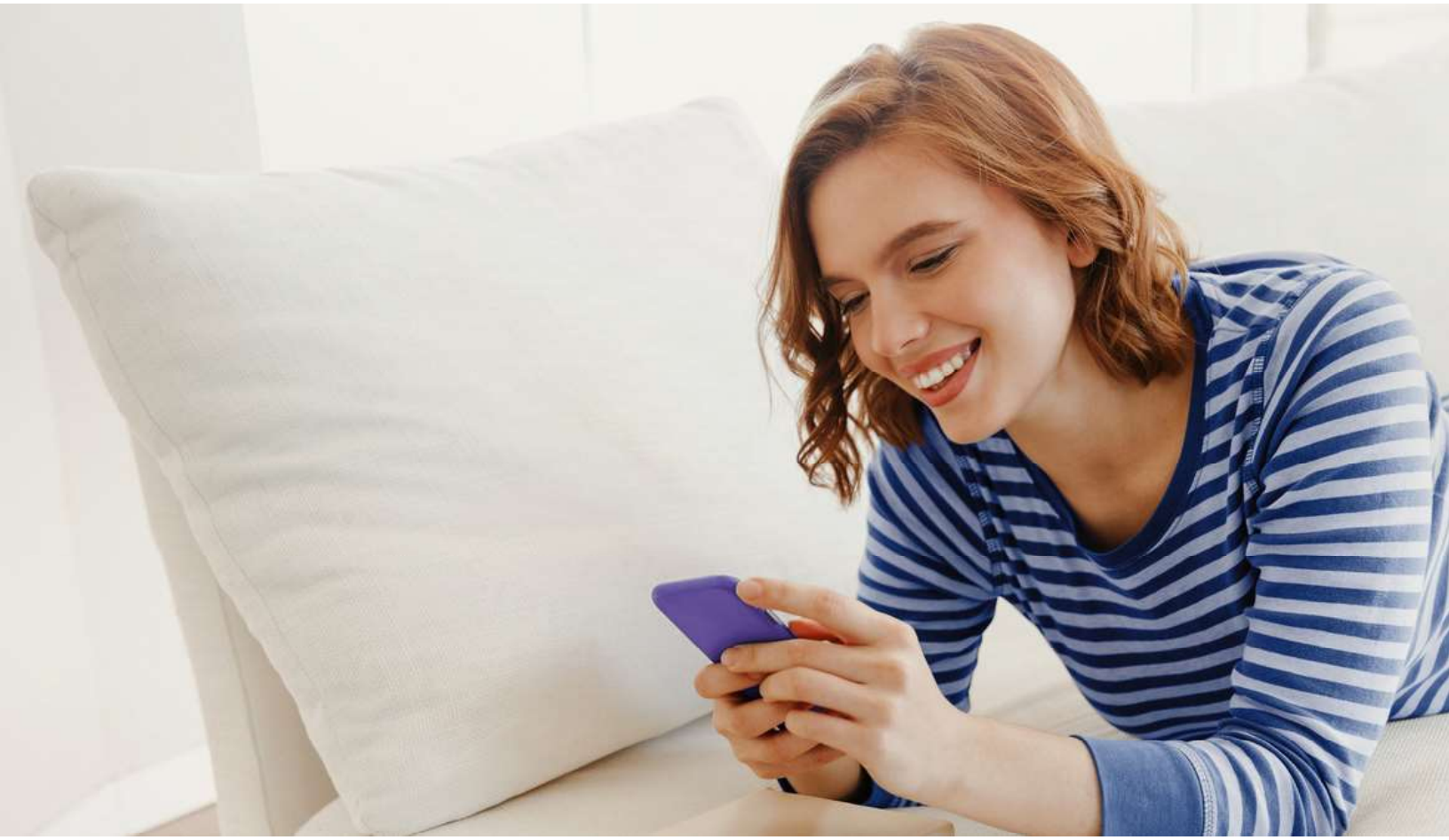
Dependent coverage

Dependent Eligibility:

Enrolled students may also insure their eligible dependents at the time the student is first able to enroll in the plan (within 14 days of the start of the policy). Eligible dependents are the student's legal spouse and dependent children under 26 years of age. Students who enroll for a qualifying life event do not have the option to enroll dependents until the following academic year. Current students also have the option of enrolling their newborn or adopted child as a qualifying life event if enrollment is within thirty-one (31) days of the date of birth or adoption. Enrollments must be for the same coverage period as that of the enrolled student.

To enroll dependents, please sign in to your **My Account**.

Dependent/Spouse/Child Coverage period	Coverage start date	Coverage end date	Rates	Rates Spouse + Child
Annual	8/15/2025	8/14/2026	$4,230	$8,434
Fall	8/15/2025	1/4/2026	$1,699	$3,372
Spring/Summer	1/5/2026	8/14/2026	$2,609	$5,192
Summer	5/10/2026	8/14/2026	$1,169	$2,312
Intl LLM	8/1/2025	6/30/2026	$4,022	$8,018
Intl LLM Fall	8/1/2025	12/31/2025	$1,814	$3,602
Intl LLM Spring	1/1/2026	6/30/2026	$2,137	$4,248



Important notes

Benefits for newborn infant, adopted or foster child

Newborn infant:

All health insurance benefits applicable for children will be payable with respect to a child born to the Named Insured or Dependents after the Effective Date and while the coverage is in force, from the moment of birth. However, with respect to a newborn infant of a Dependent other than the Insured Person's spouse, the coverage for the newborn infant terminates 18 months after the birth of the newborn infant. The coverage for newborn infant consists of coverage for Injury or Sickness including necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation cost of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending Physician as necessary to protect the health and safety of the newborn infant. The coverage of such transportation may not exceed the Allowed Amount.

The Insured may notify the Company, in writing of the birth of the child not less than 30 days after the birth. If timely notice is given, the Company may not charge an additional premium for coverage of the newborn infant for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of birth. The Company will not deny coverage for a child due to failure to timely notify the Company of the child.

Adopted or foster child:

The Named Insured's adopted child or foster child will be covered to the same extent as other Dependents from the moment of placement in the residence of the Named Insured. In the case of a newborn adopted child, coverage begins at the moment of birth and applies as for a newborn infant defined above if a written agreement to adopt such child has been entered into by the Named Insured prior to the birth of the child whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Named Insured's residence. The Insured may notify the Company, in writing, of the adopted or foster child not less than 30 days after placement or adoption If timely notice is given, the Company may not charge an additional premium for coverage of such child for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of adoption or placement. The Company will not deny coverage for a child due to failure to timely notify the Company of such child.

Benefits will also be provided for a foster child or other child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

Mid-Year Changes/Qualified Life Event

Students may apply to add the University of Miami Student Health Insurance Plan in the middle of the year - for themselves or their newborn, adopted child or foster child when experiencing Qualifying Events. Specific circumstances that may qualify for a change in your insurance enrollment status in the middle of a plan year (but are not limited to):

- Loss of existing health insurance coverage (e.g., aging off parents' coverage, parent/spouse terminating a job)
- Need to add dependent coverage due to the birth of a child/adopted children

You must contact UHCSR to request the enrollment form within 31 days of the life-changing event or circumstance. Please call customer service at **1-833-931-0533** or email **studenthealth@miami.edu** for further assistance.

Medicare eligibility

You are not eligible to enroll in the student health insurance plan if you have Medicare at the time of enrollment in this student plan. This plan does not provide coverage for people who have Medicare.

If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage will not end due to obtaining Medicare.

As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Termination

Withdrawal from classes (leave of absence)

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been paid. No premium will be refunded. Refunds of premiums are allowed only upon entry into the armed forces.

Withdrawal from classes (other than leave of absence)

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Students must actively attend classes for at least the first 31 days (unless an official medical withdrawal has been approved by the Student Health Service) after the date for which coverage is purchased.

If you withdraw from classes more than 31 days after the policy's start date, your coverage will continue until the end of the period for which you have paid the premium. Refunds for premiums will not be issued.

If you withdraw from classes to join the armed forces of any country, your coverage will terminate on the date of your enlistment. We will provide a pro-rated refund of your premium.

In-network provider network

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means the 50 mile radius around the local school campus the Named Insured is attending.

You should establish a relationship with a doctor who knows your health history and goals, helping to coordinate your care. Choosing the right provider can help you maximize your savings and reduce out-of-pocket costs. To find a provider, you can use the UHCSR mobile app, visit **uhcsr.com/miami**, or call Customer Service at **1-800-767-0700**.

Pre-admission notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS: The patient, Physician or Hospital should telephone **1-877-295-0720** at least five working days prior to the planned admission.
2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS: The patient, patient's representative, Physician or Hospital should telephone **1-877-295-0720** within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling **1-877-295-0720**.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, pre-notification is not a guarantee that benefits will be paid.

Benefits

Coordination of Benefits (COB)

If you have health coverage under multiple plans, we will collaborate with your other plan(s) to determine the payment responsibilities of each. This process is known as Coordination of Benefits. You can find a detailed explanation of the COB provision in the Certificate available on **uhcsr.com/miami**.

Description of Benefits

This document provides a summary of the benefits available under the student health insurance plan. The plan has certain exclusions and limitations on coverage amounts. While this summary highlights key features of the plan, additional important details are outlined in the Certificate. For the complete plan description, please refer to the Certificate available at **uhcsr.com**. The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

Select Care Providers

- University of Miami Hospital
- Anne Bates Leach Eye Hospital
- University of Miami Hospital & Clinics Sylvester Comprehensive Cancer Center
- Sylvester Comprehensive Cancer Center
- Lennar Walgreens

Benefits	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Overall Plan Maximum	**There is no Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)**		
Plan Deductible	$300 (Per Insured Person, Per Policy Year)	$300 (Per Insured Person, Per Policy Year)	$750 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan certificate for details about how the Out-of-Pocket Maximum applies.	$5,500 (Per Insured Person, Per Policy Year) $11,000 (For all Insureds in a Family, Per Policy Year)	$5,500 (Per Insured Person, Per Policy Year) $11,000 (For all Insureds in a Family, Per Policy Year)	$6,000 (Per Insured Person, Per Policy Year)
Coinsurance All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.	90% of Allowed Amount except as noted below **Student pays**: 10% **Company pays**: 90%	70% of Allowed Amount except as noted below **Student** pays: 30% **Company pays**: 70%	60% of Allowed Amount except as noted below **Student pays**: 40% **Company pays**: 60%
Inpatient	**Select Provider Benefits**	**Preferred Provider Benefits**	**Out-of-Network Provider Benefits**
Room and Board Expense	**Inpatient**: 90% of Allowed Amount after Deductible	**Inpatient**: 70% of Allowed Amount after Deductible	**Inpatient**: 60% of Allowed Amount after Deductible
Intensive Care	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	**Inpatient**: 90% of Allowed Amount after Deductible	**Inpatient**: 70% of Allowed Amount after Deductible	**Inpatient**: 60% of Allowed Amount after Deductible

Inpatient	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Routine Newborn Care	90% of Allowed Amount not subject to Deductible	70% of Allowed Amount not subject to Deductible	60% of Allowed Amount not subject to Deductible
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	**Inpatient:** 90% of Allowed Amount after Deductible	**Inpatient:** 70% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Registered Nurse's Services	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	100% of Allowed Amount not subject to Deductible	$40 Copay per visit 100% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Outpatient	**Select Provider Benefits**	**Preferred Provider Benefits**	**Out-of-Network Provider Benefits**
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	**Inpatient:** 90% of Allowed Amount after Deductible **Outpatient:** 90% of Allowed Amount after Deductible	**Inpatient:** 70% of Allowed Amount after Deductible **Outpatient:** 70% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient:** 60% of Allowed Amount after Deductible
Day Surgery Miscellaneous	**Outpatient:** 90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	**Outpatient:** 60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Physician's Visits	100% of Allowed Amount not subject to Deductible	$40 Copay per visit 100% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Cleft Lip and Cleft Palate in the Certificate.	$20 Copay per visit 100% of Allowed Amount after Deductible	$20 Copay per visit 100% of Allowed Amount after Deductible	**Outpatient office visits:** 60% of Allowed Amount after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$200 Copay per visit 100% of Allowed Amount after Deductible The Copay will be waived if admitted to the Hospital	$200 Copay per visit 100% of Allowed Amount after Deductible The Copay will be waived if admitted to the Hospital	$200 Copay per visit 100% of Allowed Amount after Deductible The Copay will be waived if admitted to the Hospital
Diagnostic X-ray Services	$50 Copay per visit 100% of Allowed Amount not subject to Deductible	$50 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Radiation Therapy	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	$50 Copay per visit 100% of Allowed Amount not subject to Deductible	$50 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Tests & Procedures	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Injections	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Chemotherapy	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Prescription Drugs *See UHCP Prescription Drug Benefit Rider for additional information in the Certificate. *Lennar Walgreens is a Select Provider: University of Miami - Lennar Center 5555 PONCE DE LEON BLVD Coral Gables, FL 33146	$10 Copay per prescription Tier 1 $35 Copay per prescription Tier 2 $70 Copay per prescription Tier 3 up to a 30-day supply per prescription not subject to Deductible	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $20 Copay per prescription Tier 1 $45 Copay per prescription Tier 2 $85 Copay per prescription Tier 3 $150 Copay per prescription for Specialty drugs up to a 30-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2 times the retail Copay up to a 90-day supply	$45 Copay per prescription generic drug $85 Copay per prescription brand-name drug 100% of billed charge up to a 30-day supply per prescription not subject to Deductible
Ambulance Services	$200 Copay per visit 100% of Allowed Amount after Deductible	$200 Copay per visit 100% of Allowed Amount after Deductible	$200 Copay per visit 100% of Allowed Amount after Deductible
Durable Medical Equipment	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Consultant Physician Fees	100% of Allowed Amount not subject to Deductible	$40 Copay per visit 100% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Not available	Allowed Amount after Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid for removal of impacted wisdom teeth only. See Section 8 Dental Benefits in the Certificate.	Not available	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness

Other	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Mental Illness Treatment	**Inpatient:** 90% of Allowed Amount after Deductible **Outpatient office visits:** 100% of Allowed Amount Not subject to Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Inpatient:** 70% of Allowed Amount after Deductible **Outpatient office visits:** **$20 Copay per visit** 100% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 60% of Allowed Amount after Deductible
Substance Use Disorder Treatment	**Inpatient:** 90% of Allowed Amount after Deductible **Outpatient office visits:** 100% of Allowed Amount Not subject to Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Inpatient:** 70% of Allowed Amount after Deductible **Outpatient office visits:** **$20 Copay per visit** 100% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 60% of Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	100% of Allowed Amount	60% of Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy See Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery in the Certificate.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes in the Certificate.	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Home Health Care 60 visits maximum per Policy Year.	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospice Care	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	**Inpatient:** 90% of Allowed Amount after Deductible	**Inpatient:** 70% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible

Other	Select Provider Benefits	Preferred Provider Benefits	Out-of-Network Provider Benefits
Skilled Nursing Facility 60 days maximum per Policy Year.	90% of Allowed Amount after Deductible	70% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	$50 Copay per visit 100% of Allowed Amount after Deductible	$50 Copay per visit 100% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	**Outpatient office visits:** 100% of Allowed Amount Not subject to Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 100% of Allowed Amount Not subject to Deductible	**Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Services and Prescription Drugs:** 60% of Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See the Certificate for Pediatric Dental and Vision Services benefits	See the Certificate for Pediatric Dental and Vision Services benefits	See the Certificate for Pediatric Dental and Vision Services benefits
Allergy injections Treatment performed at a physician's or specialist office.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Voluntary sterilization for males	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Surgical, hormone replacement therapy, and counseling treatment	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
Adult Vision Care Limited to covered persons age 19 and over. Benefits limited to 1 routine vision exam (including refraction) per Policy Year Eye Examinations covered only at Student Health Service-designated facility for one visit annually at a $20 Copayment.	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	No Benefits	No Benefits
Routine physical exam Limited to 1 visit per Policy Year.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Routine gynecological exams (including Pap smears and cytology tests) performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office Limited to 1 visit per Policy Year.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Travel and Lodging Expenses Related to Transplantion Services.	$50 per night/insured $50 per night/companion $10,000 lifetime maximum per transplant	$50 per night/insured $50 per night/companion $10,000 lifetime maximum per transplant	$50 per night/insured $50 per night/companion $10,000 lifetime maximum per transplant

Exclusions and limitations

Please review the Certificate and the attached riders at **uhcsr.com/miami** for a full explanation of benefits, exclusions, and limitations that may apply.

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
   This exclusion does not apply to benefits specifically provided in the Policy.
3. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance
   - .Correct deformity caused by birth defects or growth defects.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.
     This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function.
7. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).
     This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of a Congenital Condition, infection or Injury.
   - Benefits for Cleft Lip and Cleft Palate.
   - Benefits for Child Health Assurance.
   - Benefits for Newborn Infant, Adopted or Foster Child.
   - Benefits specifically provided in the Policy.
10. Hypnosis.
11. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
13. Investigational services.
14. Lipectomy.
15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony
16. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents or sexual enhancement drugs.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Premarital examinations.

- Impotence, organic or otherwise.
- Reversal of sterilization procedures

18. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.

19. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To Physician services, soft lenses or sclera shells for the treatment of aphakic patients.
- To initial glasses or contact lenses following cataract surgery.
- To benefits specifically provided in Pediatric Vision Services.
- To benefits specifically provided in Benefits for Newborn Infant, Adopted or Foster Child.
- To benefits specifically provided in Benefits for Child Health Assurance.
- To benefits specifically provided in the Policy.

20. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.

21. Speech therapy, except as specifically provided in Benefits for Cleft Lip and Cleft Palate or except as specifically provided in the Policy. Naturopathic services.

22. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

23. Supplies, except as specifically provided in the Policy.

24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.

25. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

26. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

27. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

3. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.

4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.

5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

7. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.

8. General vitamins, except the following, which require a Prescription Order or Refill:

- Prenatal vitamins.
- Vitamins with fluoride.
- Single entity vitamins.

9. Certain unit dose packaging or repackagers of Prescription Drug Products.

10. Medications used for cosmetic or convenience purposes.

11. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.

12. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.

13. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription

Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)

14. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
15. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
16. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
17. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
19. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
      For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
      Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
20. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
21. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
22. Diagnostic kits and products, including associated services.
23. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
24. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
25. A Prescription Drug Product that contains marijuana, including medical marijuana.

Pediatric Dental Exclusions

Except as may be specifically provided in the rider for Pediatric Dental Services of Section 2 in the Certificate: Benefits for Covered Dental Services, benefits are not provided under this rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this rider in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. 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 Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. 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.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this rider to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. 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 Policy.

Prior authorization

The cost of medications is increasing, making it essential that members receive the correct clinical care, including the right medication, in order to ensure both efficacy and safety.

With the UnitedHealthcare® Prior Authorization program, the member must meet specific clinical requirements before a medication is approved for coverage.

Prior authorization programs impact 40% of total drug costs, but only 5% of all claims.

Helps promote safe and effective medication use and save on pharmacy costs.

Our prior authorization program is designed and managed by a team of highly skilled clinical pharmacists, under the direction of the UnitedHealthcare National Pharmacy & Therapeutics Committee, who are comprised of specialists in various therapeutic areas. This program is based on credible clinical practice guidelines, FDA-approved product labeling, published clinical research, and feedback from experienced healthcare professionals.

This rigorous, evidence-based review ensures that coverage is based on approved or proven use of medications and includes:

- Diagnosis
- Dose and duration
- Genetic testing as appropriate
- Other clinical information

Includes notification and medical necessity

Notification

The provider must obtain the necessary diagnosis information in order to determine if the prescription meets the plan benefit coverage and is compliant with the U.S. Food and Drug Administration (FDA) guidelines for medication and diagnosis.

Medical necessity

Specific conditions must be met for a medication to be deemed medically necessary, including:

- Is the medication clinically appropriate?
- Is the medication appropriate for the diagnosis?

Step therapy

Many medical conditions have various drugs available for treatment, but prices of these drugs can differ significantly. Step therapy helps get the needed treatment while potentially saving money. We strongly advise you to talk to your doctor about different treatment and medication options.

Here's how step therapy works

1. You get a prescription.
2. The step therapy program requires you to try Step 1 drugs before Step 2 drugs can be covered.
3. If Step 1 drugs do not meet your needs, or if your doctor recommends continuing with Step 2 drugs, your doctors must obtain a prior authorization (PA) from us for coverage.
4. If the PA is approved, you can keep filling your prescription as usual. If the PA is not approved, you may have to pay the full cost of the drug(s). The amount you pay for the drug(s) will not count toward any deductible or out-of-pocket limits you may have.

What are Step 1 and Step 2 drugs?

Step 1 drugs usually cost less and are clinically appropriate and effective to treat the same conditions as Step 2 drugs.

Right to request an exclusion exception

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call **1-800-767-0700**. The Company will notify the Insured Person of the Company's determination within 72 hours.

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

Urgent requests

If the Insured Person's request requires immediate action and a delay could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

External reviews

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling **1-800-767-0700**. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited external review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling **1-800-767-0700** or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

Additional assistance services

How to access assistance and evacuation services

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at **www.uhcsr.com/MyAccount** and select Value Added Benefits: Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

- Caller's name, telephone and (if possible) fax number, and relationship to the Insured Person.
- Insured Person's name, age, sex, and ID Number as listed on the Insured Person's Medical ID card.
- Description of the Insured Person's condition.
- Name, location, and telephone number of hospital, if applicable.
- Name and telephone number of the attending physician.
- Information on where the physician can be immediately reached.

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

Questions?

For any questions, please call Customer Service at **1-800-767-0700**

United Healthcare | UNIVERSITY OF MIAMI

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

ATTENTION: You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free phone number listed on your ID card. (TTY: 711).

ትኩረት፦ በቀጠሮዎ ጊዜ ወይም ከእኛ ጋር ሲሆኑ ከሐኪምዎ ጋር ለመነጋገር አስተርጓሚ ማግኘት ይችላሉ። **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎቶች እና ነፃ ግንኙነቶች እንደ ትልቅ ህትመት ባሉ ሌሎች ቅርጸቶች ለእርስዎ ይገኛሉ። ለህክምና ዕቅዶች ወደ **1-866-260-2723**፣ ለእይታ ዕቅዶች ወደ **1-800-638-3120**፣ ለጥርስ ዕቅዶች ወደ **1-877-816-3596** ይደውሉ ወይም በአባል መታወቂያ ካርድዎ ላይ ወደተዘረዘረው ነፃ የስልክ ቁጥር ይደውሉ። (TTY: 711)።

يرجى الانتباه: يمكنك الحصول على مترجم فوري لمساعدتك في التحدث مع طبيبك خلال الموعد أو معنا. إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل على **1-866-260-2723** للخطط الطبية، أو
1-800-638-3120 لخطط رعاية البصر، أو **1-877-816-3596** لخطط الأسنان، أو اتصل برقم الهاتف المجاني المدرج على بطاقة هوية العضو الخاصة بك. (TTY: 711)

মনোযোগ দিয়ে শুনুন: আপনার অ্যাপয়েন্টমেন্টের সময় আপনার ডাক্তারের সাথে কথা বলার জন্য বা আমাদের সাথে কথা বলার জন্য আপনি একজন দোভাষী পেতে পারেন। আপনি যদি **বাংলা (Bengali)** এ কথা বলেন, তাহলে বিনামূল্যের ভাষা সহায়তা পরিষেবা এবং অন্যান্য বিনামূল্যের বিভিন্ন যোগাযোগ পদ্ধতি, যেমন বড় মুদ্রণ, আপনার জন্য উপলব্ধ থাকবে। মেডিকেল প্ল্যানের জন্য কল করুন **1-866-260-2723** নম্বরে, ভিশন প্ল্যানের জন্য কল করুন **1-800-638-3120** নম্বরে, ডেন্টাল প্ল্যানের জন্য কল করুন **1-877-816-3596** নম্বরে, অথবা আপনার সদস্য আইডি কার্ডে টোল-ফ্রি ফোন নম্বরে কল করুন। (TTY: 711)

ចំណាំ៖ អ្នកអាចស្នើសុំអ្នកបកប្រែ ដើម្បីទំនាក់ទំនងជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាត់ជួប ឬនិយាយជាមួយយើងខ្ញុំ។ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian Mon-Khmer)** មានសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ការទំនាក់ទំនងដោយឥតគិតថ្លៃ ក្នុងទម្រង់ផ្សេងទៀត ដូចជាអក្សរធំ មានសម្រាប់អ្នក។ សូមហៅទូរសព្ទទៅ **1-866-260-2723** សម្រាប់គម្រោងវេជ្ជសាស្ត្រ **1-800-638-3120** សម្រាប់គម្រោងថែទាំភ្នែក **1-877-816-3596** សម្រាប់គម្រោងថែទាំធ្មេញ ឬហៅទូរសព្ទទៅលេខទូរសព្ទដោយមិនគិតថ្លៃ ដែលបានចុះក្នុងបណ្ណសមាជិករបស់អ្នក។ (TTY៖ 711)។

ATENSHUN: Kuŋka me liye ayu yo interprete para ughul maghal na dokto ya eppunghi me guahu. Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane bwe me sew format, ta tipel lane, bwe bwale tepangiyom. Kali **1-866-260-2723** para ughul Lalap ni ughul tipiye, **1-800-638-3120** para ughul Lalap ni tipiye nu mata, **1-877-816-3596** para ughul Lalap ni tipiye nu apapa, o kali ewe kali rerekkepal ni Nuumur ni telepon yeeg listed me ni Kaaret ni meybur ID-mu. (TTY: 711).

ATENSYON: Siña hao humosga un intérprete para kumuentos yan i doktermu gi ora di i konsulta-mu pat yan hame. Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha, taiguihi i para mana'dångkolo i inemprenta. Kålle **1-866-260-2723** para Planån Mediku, **1-800-638-3120** para Planån Visión, **1-877-816-3596** para Planån Dental, pat kålle i númeru gratut na teleponu na esta på'go gi kåtta ID para miembro -mu. (TTY: 711).

請注意：您可以獲得一位口譯員，在您看診時與您的醫生溝通或平常與我們溝通。如果您說**中文 (Chinese)**，我們可為您提供免費的語言協助服務與其他溝通格式，例如大字版文件。醫療計劃請致電**1-866-260-2723**，視力計劃請致電**1-800-638-3120**，牙科計劃請致電 **1-877-816-3596**，或撥打您會員卡上所列的免付費電話號碼。(TTY：711)。

توجه: شما می‌توانید یک مترجم برای صحبت با پزشک خود در زمان ویزیت یا برای گفتگو با ما، درخواست کنید. اگر **فارسی (Farsi)**، صحبت می‌کنید، خدمات رایگان کمک زبانی و خدمات رایگان ارتباطاتی در سایر قالب‌ها، مانند چاپ با حروف درشت، در دسترس شما هستند. برای برنامه‌های پزشکی با شماره **1-866-260-2723** و برای طرح چشم پزشکی با شماره **1-800-638-3120** و برای طرح دندانپزشکی با شماره **1-877-816-3596**، یا با (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط تلفن رایگان سازمان

ATTENTION : Vous pouvez demander à un(e) interprète de parler à votre médecin au moment de votre rendez-vous ou avec nous. Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le **1-866-260-2723** pour les régimes médicaux, le **1-800-638-3120** pour les régimes de soins de la vue, le **1-877-816-3596** pour les régimes de soins dentaires, ou appelez le numéro de téléphone gratuit indiqué sur votre carte de membre. (TTY : 711).

ACHTUNG: Sie können für Gespräche mit Ihrem Arzt bei Ihrem Termin oder mit uns einen Dolmetscher anfordern. Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie **1-866-260-2723** für Krankenversicherungen, **1-800-638-3120** für Augenversicherungen, **1-877-816-3596** für Zahnversicherungen oder die gebührenfreie Telefonnummer auf Ihrer Mitgliedskarte an. (TTY: 711).

ΠΡΟΣΟΧΗ: Μπορείτε να πάρετε έναν διερμηνέα για να μιλήσετε με το γιατρό σας στο ραντεβού σας ή για να μιλήσετε μαζί μας. Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε στο **1-866-260-2723** για ιατρικά προγράμματα, στο **1-800-638-3120** για οφθαλμολογικά προγράμματα, στο **1-877-816-3596** για οδοντιατρικά προγράμματα ή καλέστε τον αριθμό τηλεφώνου χωρίς χρέωση που αναγράφεται στην κάρτα μέλους σας. (TTY: 711).

ધ્યાન આપો: તમે તમારી મુલાકાત સમયે અથવા અમારી સાથે તમારા ડૉક્ટર સાથે વાત કરવા માટે દુભાષિયા મેળવી શકો છો. જો તમે **ગુજરાતી (Gujarati)**, બોલો છો, તો મફત ભાષા સહાયતા સેવાઓ અને અન્ય ફોર્મેટમાં મફત સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. મેડિકલ પ્લાન માટે **1-866-260-2723**, વિઝન પ્લાન માટે **1-800-638-3120**, ડેન્ટલ પ્લાન માટે **1-877-816-3596** પર કૉલ કરો અથવા તમારા સભ્ય આઈડી કાર્ડ પર સૂચિબદ્ધ ટોલ-ફ્રી ફોન નંબર પર કૉલ કરો. (TTY: 711).

ATANSYON: Ou ka jwenn yon entèprèt pou pale ak doktè ou a nan moman randevou w la oswa avèk nou. Si w pale **Kreyòl Ayisyen (Haitian Creole)**, sèvis asistans lang gratis ak kominikasyon gratis nan lòt fòma, tankou gwo lèt, disponib pou ou. Rele **1-866-260-2723** pou Plan Medikal, **1-800-638-3120** pou Plan Vizyon, **1-877-816-3596** pou Plan Dantè, oswa rele nimewo telefòn gratis ki endike sou kat ID manm ou a. (TTY: 711).

ध्यान दें: आप अपनी अपॉइंटमेंट के समय या हमारे साथ अपने डॉक्टर से बात करने के लिए एक दुभाषिया प्राप्त कर सकते हैं। यदि आप **हिन्दी (Hindi)** बोलते हैं, तो मुफ्त भाषा सहायता सेवाएँ और बड़े प्रिंट जैसे अन्य प्रारूपों में मुफ्त संचार सेवा आपके लिए उपलब्ध हैं। मेडिकल प्लान के लिए **1-866-260-2723** पर कॉल करें, विजन प्लान के लिए **1-800-638-3120** पर, डेंटल प्लान के लिए **1-877-816-3596** पर कॉल करें, या अपने सदस्य आईडी कार्ड पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें। (TTY: 711)

CEEB TOOM: Koj tuaj yeem tau txais ib tug neeg txhais lus tham nrog koj tus kws kho mob thaum lub sijhawm kev teem caij los sis thaum tham nrog peb. Yog tias koj hais **Lus Hmoob (Hmong)**, yuav muaj cov kev pab cuam txhais lus pub dawb thiab kev sib txuas lus ua lwm hom qauv, xws li luam ua tus ntawv loj rau koj. Hu rau **1-866-260-2723** rau Cov Phiaj Xwm Kho Mob, **1-800-638-3120** rau Cov Phiaj Xwm Kho Qhov Muag, **1-877-816-3596** rau Cov Phiaj Xwm Kho Hniav, los yog hu rau tus xov tooj hu dawb uas teev rau hauv koj daim npav ID. (TTY: 711).

ATENSION: Makaalaka iti interpreter a makisarita kadakami wenno iti doktormo iti oras ti appointment-mo. No makasaoka iti **Ilocano (Ilocano)**, makaalaka iti libre a tulong iti lengguahe ken libre a pannakikomunikar iti sabali a format, kas iti dadakkel a letra. Tawagam ti **1-866-260-2723** para kadagiti Plan a Medikal, **1-800-638-3120** para kadagiti Plan para iti Panagkita, **1-877-816-3596** para kadagiti Plan para iti Ngipen, wenno tawagam ti libre a numero ti telepono a nailista iti ID card-mo kas miembro. (TTY: 711).

ATTENZIONE: il giorno del Suo appuntamento, può richiedere i servizi di un interprete per parlare con il Suo medico o con noi. Se parla **italiano (Italian)**, sono disponibili gratuitamente servizi di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero **1-866-260-2723** per i piani sanitari, il numero **1-800-638-3120** per i piani oculistici e il numero **1-877-816-3596** per i piani dentistici, oppure chiami il numero verde riportato sul Suo tesserino identificativo. (TTY: 711).

ご注意：ご予約にお越しの際またはご来院の際、医師とお話になるための通訳者を手配することが可能です。あなたが**日本語 (Japanese)** をお話になる場合、無料の言語支援サービスおよび大きい活字など他の形式による無料のコミュニケーションをご利用になれます。医療プランについては **1-866-260-2723**、眼科プランについては **1-800-638-3120**、歯科プランについては **1-877-816-3596** までお電話いただくか、メンバー ID カードに記載の通話料無料の番号までお電話ください。(TTY: 711)。

주의: 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다. **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 큰 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 의료 플랜의 경우 **1-866-260-2723**, 안과 플랜의 경우 **1-800-638-3120**, 치과 플랜의 경우 **1-877-816-3596**번으로 전화하거나 귀하의 회원 ID 카드에 기재된 무료 전화번호로 전화하십시오. (TTY: 711).

ໝາຍເຫດ: ທ່ານສາມາດຂໍນາຍແປພາສາເພື່ອເວົ້າກັບທ່ານໝໍໃນເວລາທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ **ພາສາລາວ (Lao)**, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ ແລະ ການສື່ສານຟຣີໃນຮູບແບບອື່ນໆ, ເຊັ່ນ: ການພິມຂະໜາດ ໃຫຍ່, ແມ່ນມີໃຫ້ທ່ານ. ໂທ **1-866-260-2723** ສຳລັບແຜນການທາງການແພດ, **1-800-638-3120** ສຳລັບແຜນການທາງສາຍຕາ, **1-877-816-3596** ສຳລັບແຜນການທາງແຂ້ວ, ຫຼື ໂທຫາເບີໂທຟຣີທີ່ລະບຸໄວ້ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.(TTY: 711).

SHOOH: Nánihoot’áaní góne’ ne’azee’ íí’íní bich’į’ yáníłti’ doodago nihí nihich’į’ yáníłti’go ata’ halne’í ła’ naayílt’eehgo bíighah. **Diné (Navajo)** bizaad bee yáníłti’to, t’áá jiik’eh saad bee áka’e’eyeed bee áka’anída’ow’í dóó t’áá jíík’eh nááná łahgo át’éego bee hada’dilyaaígíí bee ahił hane’, díí nitsaago bik’e’ashchíní, ná dahólǫ. Ats’íís Nánél’jįh Bee Hada’dít’éhí biniiyé kohjį’ **1-866-260-2723** hodíilnih, Anáá’ Bee Hoot’íní Bee Hada’dít’éhí biniiyé kohjį’ **1-800-638-3120** hodíilnih, Awoo’ Bee Hada’dít’éhí biniiyé kóhjį’ **1-877-816-3596** hodíilnih, doodago bee nił ha’dít’éhí ninaaltsoos nitł’izí bee nééhóziní ID bąąh t’áá jiik’eh námboo bee dahane’í biká’ígíí bee hodíilnih. (TTY: 711).

ध्यान दिनुहोस्: तपाईंले आफ्नो अपोइन्टमेन्टको समयमा वा हामीसँग आफ्नो डाक्टरसँग कुरा गर्न दोभाषे लिन सक्नुहुन्छ। तपाईं **नेपाली (Nepali)** बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र ठूलो अक्षर जस्ता अन्य ढाँचाहरूमा निःशुल्क सञ्चार सेवाहरू तपाईंको लागि उपलब्ध छन्। चिकित्सा योजनाहरूको लागि **1-866-260-2723** भिजन योजनाहरूको लागि **1-800-638-3120** दन्त योजनाहरूको लागि **1-877-816-3596** मा कल गर्नुहोस्, वा तपाईंको सदस्य परिचयपत्रमा सूचीबद्ध टोल-फ्री फोन नम्बरमा कल गर्नुहोस्। (TTY: 711)

WICHDICH: Du darfscht en Interpreter griege fer schwetze mit dei Dokter an dei Appointment odder mit uns. Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht un brauchscht Hilf fer communicat-e, kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Call **1-866-260-2723** fer Plans as zu duh hen mit Dokteres, **1-800-638-3120** fer Plans as zu duh hen mit Sehne, **1-877-816-3596** fer Plans as zu duh hen mit Zaeh, odder call die Toll-Free Phone Number as uff dei ID Card is. (TTY: 711).

UWAGA: Możesz poprosić tłumacza o pomoc w rozmowie z lekarzem w czasie wizyty lub z nami. Osoby mówiące w języku **polskim (Polish)**, mają dostęp do bezpłatnej usługi pomocy językowej i bezpłatnej komunikacji w innych formatach, takich jak duży druk. Zadzwoń pod numer **1-866-260-2723** w celu uzyskania informacji o planach medycznych, **1-800-638-3120** o planach okulistycznych, **1-877-816-3596** o planach stomatologicznych lub zadzwoń pod bezpłatny numer telefonu podany na karcie członkowskiej. (TTY: 711).

ATENÇÃO: Você pode ter um intérprete para falar com o médico no momento da consulta ou conosco. Se você fala **português (Portuguese)**, há serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, disponíveis para você. Ligue para **1-866-260-2723** para planos médicos, **1-800-638-3120** para planos oftalmológicos, **1-877-816-3596** para planos odontológicos ou ligue para o número de telefone gratuito listado no seu cartão de ID de membro. (TTY: 711).

ਧਿਆਨ ਦਿਓ: ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਮੈਡੀਕਲ ਯੋਜਨਾਵਾਂ ਲਈ **1-866-260-2723**, ਵਿਜ਼ਨ ਯੋਜਨਾਵਾਂ ਲਈ **1-800-638-3120**, ਡੈਂਟਲ ਯੋਜਨਾਵਾਂ ਲਈ **1-877-816-3596** 'ਤੇ ਕਾਲ ਕਰੋ, ਜਾਂ ਆਪਣੇ ਮੈਂਬਰ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਟੋਲ-ਫ੍ਰੀ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

ВНИМАНИЕ! Вы можете воспользоваться услугами устного переводчика для общения с вашим врачом во время приема или через наши услуги. Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Позвоните по телефону **1-866-260-2723** для медицинских планов, **1-800-638-3120** для планов по охране зрения, **1-877-816-3596** для планов по стоматологическим услугам или на линию для бесплатного звонка, указанную на вашей идентификационной карточке участника. (Линия TTY: 711).

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au **1-866-260-2723** mo Fuafuaga Fa'afoma'i, **1-800-638-3120** mo Fuafuaga Va'ai, **1-877-816-3596** mo Fuafuaga Nifo, pe vala'au le numera telefoni e leai se totogi o lo'o lisiina i luga o lau pepa ID tagata. (TTY: 711).

FIIRO GAAR AH: Waxaad heli kartaa turjumaan si aad ula hadasho dhakhtarkaaga wakhtiga ballanta ama annaga. Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac **1-866-260-2723** wixii ah Qorshayaasha Caafimaadka, **1-800-638-3120** Qorshooyinka Aragtida, **1-877-816-3596** wixii ah Qorshooyinka Ilkaha, ama wac lambarka telefoonka bilaashka ah ee ku qoran kaarka aqoonsiga xubinta. (TTY: 711).

ATENCIÓN: Puede conseguir un intérprete para hablar con nosotros o con su médico durante su cita. Si usted habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia en otros idiomas y comunicaciones gratuitas en otros formatos, como letra grande. Llame al **1-866-260-2723** para los planes médicos, al **1-800-638-3120** para los planes de la vista y al **1-877-816-3596** para los planes dentales, o llame al número de teléfono gratuito que aparece en su tarjeta de identificación de membresía. (TTY: 711).

PAUNAWA: Maaari kang makakuha ng interpreter upang makausap ang iyong doktor sa panahon ng iyong appointment o sa pakikipag-usap sa amin. Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa **1-866-260-2723** para sa Mga Planong Medikal, **1-800-638-3120** para sa Mga Plano para sa Paningin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tumawag nang libre sa numero ng telepono na nakalista sa iyong ID card ng miyembro. (TTY: 711).

หมายเหตุ: คุณสามารถขอล่ามมาพูดคุยกับแพทย์ของคุณได้ในเวลาที่คุณนัดหมายหรือกับเรา หากคุณพูด**ภาษาไทย (Thai)** เรายินดีให้บริการช่วยเหลือด้านภาษาและการสื่อสารในรูปแบบอื่นๆ เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่โดยไม่คิดค่าใช้จ่าย โทร **1-866-260-2723** สำหรับการวางแผนทางการแพทย์ **1-800-638-3120** สำหรับการวางแผนด้านจักษุ **1-877-816-3596** สำหรับการวางแผนด้านทันตกรรม หรือโทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ในบัตรประจำตัวสมาชิกของคุณ (TTY: 711)

ЗВЕРНІТЬ УВАГУ! Під час прийому у лікаря або розмови з нами ви маєте змогу скористатися послугами усного перекладача. Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як-от набрані великим шрифтом. Телефонуйте на номер **1-866-260-2723** щодо планів медичного страхування, на номер **1-800-638-3120**, щоб дізнатися докладніше про плани страхового покриття офтальмологічних послуг, на номер **1-877-816-3596**, щоб дізнатися докладніше про плани страхового покриття стоматологічних послуг, або телефонуйте на номер безкоштовної телефонної лінії, зазначений на вашій ідентифікаційній картці учасника. (лінія TTY: 711).

توجہ فرمائیں: آپ اپنی ملاقات کے وقت یا ہمارے ساتھ اپنے ڈاکٹر سے بات کرنے کے لیے مترجم حاصل کر سکتے ہیں۔ اگر آپ **اردو (Urdu)** بولتے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیٹس مثلاً بڑے پرنٹ میں مفت مواصلات آپ کے لیے دستیاب ہیں۔ میڈیکل پلانز کے لیے **1- 866-260-2723**پر، ویژن پلانز کے لیے **1-800-638-3120**، ڈینٹل پلانز کے لیے **1-877-816-3596** پر کال کریں، یا (TTY: 711) ا

LƯU Ý: Quý vị có thể có một thông dịch viên miễn phí để nói chuyện với bác sĩ trong buổi hẹn khám của mình hoặc nói chuyện với chúng tôi. Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Hãy gọi **1-866-260-2723** cho các Chương trình Y tế, **1-800-638-3120** cho các Chương trình Nhãn khoa, **1-877-816-3596** cho các Chương trình Nha khoa, hoặc gọi số điện thoại miễn phí được ghi trên thẻ ID hội viên của quý vị. (TTY: 711).