SignatureValue plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	SignatureValue
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☑
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☐
Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☑
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☑
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free.Use it to save and pay for qualified medical expenses.	☐

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

Here's a more in-depth look at how SignatureValue works

Medical Benefits

	In Network
Annual Medical Deductible	
Individual	You do not have to pay a medical deductible.
Family	You do not have to pay a medical deductible.

**After the Annual Medical Deductible has been met.*

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	$2,000
Family	$4,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Network**
Preventive Care Services	
Preventive Care Services *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 copay or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.* *Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.*	No copay

*After the Annual Medical Deductible has been met.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Office Services - Sickness & Injury	
Allergy Testing and Treatment	
PCP Office Visit	$20 copay
Specialist Office Visit	$40 copay
Serum is covered.	
PCP Office Visits/Telehealth Services *Co-payments for Audiologist and Podiatrist visits will be the same as for the PCP.*	$20 copay
Specialist Office Visits/Telehealth Services *Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency Services and Care/Urgently Needed Services.*	$40 copay
Urgently Needed Services	
Urgent Care Services - outside medical group	$50 copay
Urgent Care Services - within medical group	$20 copay
Please consult your EOC for additional details.	
Virtual Care Services *Covered Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Network Virtual Provider by going to myuhc.com® or the telephone number on your ID card.*	No copay
Vision Refractions *Limited to 1 exam every 12 months.*	$20 copay
Emergency Care	
Ambulance Services - Emergency Ambulance	
Air Ambulance	$150 copay per transport
Ground Ambulance	$150 copay per transport
Emergency Services and Care	$250 copay
Inpatient Care	
Hospital Covered Benefits	$250 copay per day to a maximum $750 copay per Inpatient Stay

*After the Annual Medical Deductible has been met.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Inpatient Rehabilitation and Habilitative Services *(Including physical, occupational and speech therapy)*	$250 copay per day to a maximum $750 copay per Inpatient Stay
Physician Care (physician fees) - Inpatient	No copay
Skilled Nursing Facility Care *Limited to 100 days per benefit period for Skilled Nursing Facility.*	$250 copay per day to a maximum $750 copay per Inpatient Stay
Outpatient Care	
Home Health Care Visits *Limited to 100 visits per year.*	$20 copay
Laboratory Services *When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply.*	$20 copay
Outpatient Habilitative Services and Outpatient Therapy	$20 copay
Outpatient Medical Rehabilitation Therapy at a Network Free-Standing or Outpatient Facility *(Including physical, occupational and speech therapy)* *ACU/CHIRO AAM $15 copay limited to 20 visits per year*	$20 copay
Physician Care (physician fees) - Outpatient	No copay
Radiology Services Specialized Scanning and Imaging Procedures Standard *A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure.* *Additional Co-payment for office visits may apply.*	 $150 copay $20 copay
Surgery - Outpatient at a Network Free-Standing or Outpatient Surgery Facility	$125 copay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Supplies and Services	
Durable Medical Equipment *Paid at negotiated rate. Balance (if any) is your responsibility.*	$70 copay
Durable Medical Equipment for Treatment of Pediatric Asthma	No copay
Hearing Aids - Bone Anchored *Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.*	The amount you pay is based on where the covered health care service is provided.
Hearing Aids - Standard *Limited to $5,000 per year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.*	$70 copay
Hearing Exam	
PCP Office Visit	$20 copay
Specialist	$40 copay
Prosthetic and Corrective Appliances	$70 copay
Pregnancy	
Maternity Care	
Maternity Care - Inpatient	$250 copay per day to a maximum $750 copay per Inpatient Stay
Maternity Care, Tests and Procedures - PCP Office Visit	No copay
Maternity Care, Tests and Procedures - Specialist Office Visit	No copay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Mental Health Care & Substance Related and Addictive Disorder Services	
All Other Outpatient Treatment *Covered Benefits, when authorized by specified adult persons who petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan are covered at zero cost share, except for prescription drugs.* *Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.* *There is no cost for school site outpatient Mental Health Care and Substance-Related and Addictive Disorders Services.*	No copay
Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment	No copay
Inpatient *Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.*	$250 copay per day to a maximum $750 copay per Inpatient Stay
Intensive Behavioral Therapy (e.g. ABA)	No copay
Outpatient Office Visits	$40 copay
Other Services	
Acupuncture Services *Limited to 20 visits per year.*	$15 copay
Approved Clinical Trials *Approved Clinical Trial services require prior authorization by UnitedHealthcare.* *Paid at negotiated rate. Balance (if any) is your responsibility.*	The amount you pay is based on where the covered health care service is provided.
Biomarker Testing	The amount you pay is based on where the covered health care service is provided.
Bone Marrow Transplants	$250 copay per day to a maximum $750 copay per Inpatient Stay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Cochlear Implant Devices *Additional Co-payment for outpatient surgery or inpatient hospital Covered Benefits and outpatient rehabilitation therapy may apply.* *Paid at negotiated rate. Balance (if any) is your responsibility.*	$40 copay
Dental Treatment Anesthesia *Additional Co-payment for outpatient surgery or inpatient hospital Covered Benefits may apply.*	$50 copay
Depo-Provera Medication (other than contraception) *Limited to 1 Depo-Provera injection every 90 days.*	No copay
Dialysis *Additional Co-payment for office visits may apply.*	$40 copay
Emergency Medical Services Provided by a Community Paramedicine Program, a Triage to Alternate Destination Program, and a Mobile Integrated Health Program	The amount you pay is based on where the covered health care service is provided.
Emergency Room Medical Care and Follow-up Health Care Treatment for Rape and Sexual Assault All visits for the first nine months after treatment is initiated Subsequent visits after nine months treatment is initiated *There is no cost for emergency room medical care and follow-up health care treatment for a Covered Person who is treated following a rape or sexual assault for the first nine months after treatment is initiated.*	 No copay No copay
Home Test Kits for Sexually Transmitted Diseases	No copay
Hospice Services - Inpatient *Prognosis of life expectancy of one year or less.*	$250 copay per day to a maximum $750 copay per Inpatient Stay
Hospice Services - Outpatient *Prognosis of life expectancy of one year or less.*	No copay
Human Milk	No copay

*After the Annual Medical Deductible has been met.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Infertility Services	
Hospital Covered Benefits	$250 copay per day to a maximum $750 copay per Inpatient Stay
Laboratory Services	$20 copay
Outpatient Surgery at a [Network] [Participating] Free-Standing or Outpatient Surgery Facility	$125 copay
PCP Office Visit/Telehealth Services	$20 copay
Physician Care (Physician Fees)	No copay
Specialist Office Visit/Telehealth Services	$40 copay
Limited to 5 years per lifetime for cryopreservation and storage of sperm, oocytes, and embryos from the time the genetic material is first cryopreserved. *Limited to a maximum of 3 oocyte retrievals per lifetime.* *Limit includes unlimited embryo transfers.*	
Infusion Therapy *Infusion Therapy is a separate Co-payment in addition to a home health care or an office visit Co-payment.* *Paid at negotiated rate. Balance (if any) is your responsibility.*	$150 copay
Injectable Drugs *No cost for injectable immunizations, birth control, infertility and insulin.* *This benefit includes Outpatient Injectable Medications and Self-Injectable Medication.*	$150 copay
Mastectomy/Breast Reconstruction *(After mastectomy and complications from mastectomy)*	$250 copay per day to a maximum $750 copay per Inpatient Stay
Newborn Care *The newborn care Deductible and/or Co-payment does not apply when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.*	$250 copay per day to a maximum $750 copay per Inpatient Stay

*After the Annual Medical Deductible has been met.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Oral Surgery Services *Paid at negotiated rate. Balance (if any) is your responsibility.*	$125 copay
Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)	The amount you pay is based on where the covered health care service is provided.
Radiation Therapy	
Complex	$50 copay
Standard (photon beam)	No copay
Reconstructive Surgery	$250 copay per day to a maximum $750 copay per Inpatient Stay
Standard Fertility Preservation Services for Iatrogenic Infertility *Limited to 2 attempts of embryo creation per lifetime.* *Limited to 2 attempts to collect sperm for members with testicles per lifetime.* *Limited to 2 attempts to retrieve gonadal tissue per lifetime.* *Limited to 2 cycles for oocyte retrieval for members with ovaries per lifetime.*	No copay
Termination of Pregnancy *(Medical/medication and surgical).*	No copay
Vasectomy	No copay

*After the Annual Medical Deductible has been met.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Access
	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible
	In Network
Annual Pharmacy Out-of-Pocket Limit	
Individual	See the Annual Medical Out-of-Pocket Section
Family	See the Annual Medical Out-of-Pocket Section

Prescription Drug Product Tier Level	Up to a 31-day supply	Up to a 90-day supply
	In-Network Retail Pharmacy	**In-Network Mail Order Pharmacy****
Tier 1 $	$15	$37.50
Tier 2 $$	$35	$87.50
Tier 3 $$$	$75	$187.50
Tier 4 $$$$	$250	$625

* After the Annual Pharmacy Deductible has been met.
** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.
Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4.
If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance.***

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com

Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your EOC, 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.

- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the plan network and/or outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at an In-Network Retail Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The In- Network Retail Pharmacy Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from an In-Network Mail Order Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

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

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or pharmaceutical product(s) for which Benefits are provided as described under the Certificate first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

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

If you require certain Prescription Drug Products including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

Certain Preventative Care Medications may be covered at zero cost share. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

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

Other important information about your benefits

Pharmacy Exclusions and Limitations

The following exclusions and limitations apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Combined Evidence of Coverage and Disclosure Form.
- Any product dispensed solely for the purpose of weight loss unless Prior Authorized as Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- Dietary or nutritional products and food. This exclusion does not apply to authorized Medically Necessary services to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).
- Dietary or nutritional products except as described under Section 5 of your Evidence of Coverage.
- Drugs available over-the-counter.
- Experimental or Investigational Services and medications, except as described in the Evidence of Coverage in Section 5 or as required by law.
- Prescription Drug Products used for cosmetic or convenience purposes.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 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**, **1-800-537-7697** (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. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

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 русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

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.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

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.

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

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