

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	\$6,000

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	No copay

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.

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

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network
Office Services - Sickness & Injury	
Allergy Testing and Treatment	
PCP Office Visit	\$10 copay
Specialist Office Visit	\$10 copay
<i>Serum is covered.</i>	
PCP Office Visits/Telehealth Services	\$10 copay
Specialist Office Visits/Telehealth Services	\$10 copay
<i>Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services.</i>	
Urgently Needed Services	
Urgent Care Services - outside medical group	\$50 copay
Urgent Care Services - within medical group	\$10 copay
<i>Please consult your EOC for additional details.</i>	
Virtual Care Services	No copay
<i>Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to 24/7 Virtual Visits and prescription services may not be available in all states or for all groups.</i>	
Vision Refractions	\$10 copay
<i>Limited to 1 exam every 12 months.</i>	
Emergency Care	
Emergency Ambulance	
Air Ambulance	No copay
Ground Ambulance	No copay
Emergency Health Care Services	\$50 copay
Inpatient Care	
Hospital Benefits	
	No copay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network
Inpatient Rehabilitation and Habilitative Services <i>(Including physical, occupational and speech therapy)</i>	No copay
Physician Care (physician fees) - Inpatient	No copay
Skilled Nursing Facility Care <i>Limited to 100 days per benefit period for Skilled Nursing Facility.</i>	No copay
Outpatient Care	
Home Health Care Visits <i>Limited to 100 visits per year.</i>	No copay
Laboratory Services <i>When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply.</i>	No copay
Outpatient Habilitative Services and Outpatient Therapy	\$10 copay
Outpatient Medical Rehabilitation Therapy at a Network Free-Standing or Outpatient Facility <i>(Including physical, occupational and speech therapy)</i>	\$10 copay
Physician Care (physician fees) - Outpatient	\$10 copay
Radiology Services	
Specialized Scanning and Imaging Procedures	No copay
Standard <i>A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure.</i> <i>Additional Co-payment for office visits may apply.</i>	No copay
Surgery - Outpatient at a Network Free-Standing or Outpatient Surgery Facility	No copay
Supplies and Services	
Durable Medical Equipment <i>Paid at negotiated rate. Balance (if any) is your responsibility.</i>	No copay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Network

Durable Medical Equipment for Treatment of Pediatric Asthma

No copay

Hearing Aids - Bone Anchored

The amount you pay is based on where the covered health care service is provided.

Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.

Hearing Aids - Standard

No copay

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.

Hearing Exam

PCP Office Visit

\$10 copay

Specialist

\$10 copay

Prosthetic and Corrective Appliances

No copay

Pregnancy

Maternity Care

Maternity Care - Inpatient

No copay

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

No copay

Covered Health Care Services, when authorized for 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.

Inpatient

No copay

Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.

Intensive Behavioral Therapy (e.g. ABA)

No copay

Outpatient Office Visits

\$10 copay

Other Services

Bone Marrow Transplants

No copay

Chiropractic Services

\$10 copay

Limited to 20 visits per year.

Clinical Trials

The amount you pay is based on where the covered health care service is provided.

Clinical Trial services require prior authorization by UnitedHealthcare.

Paid at negotiated rate. Balance (if any) is your responsibility.

Cochlear Implant Devices

No copay

Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply.

Paid at negotiated rate. Balance (if any) is your responsibility.

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network
Dental Treatment Anesthesia	\$10 copay
<i>Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply.</i>	
Depo-Provera Medication (other than contraception)	No copay
<i>Limited to 1 Depo-Provera injection every 90 days.</i>	
Dialysis	\$10 copay
<i>Additional Co-payment for office visits may apply.</i>	
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	No copay
Subsequent visits after nine months treatment is initiated	No copay
<i>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.</i>	
Home Test Kits for Sexually Transmitted Diseases	No copay
Hospice Services - Inpatient	No copay
<i>Prognosis of life expectancy of one year or less.</i>	
Hospice Services - Outpatient	No copay
<i>Prognosis of life expectancy of one year or less.</i>	
Human Milk	No copay

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Network

Infertility Services

Hospital Covered Benefits No copay

Laboratory Services No copay

Outpatient Surgery at a [Network] [Participating] Free-Standing or Outpatient Surgery Facility No copay

PCP Office Visit/Telehealth Services \$10 copay

Physician Care (Physician Fees) No copay

Specialist Office Visit/Telehealth Services \$10 copay

Limited to a maximum of 3 oocyte retrievals per lifetime.

Limit includes unlimited embryo transfers.

Infusion Therapy No copay

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.

Injectable Drugs \$50 copay

No cost for injectable immunizations, birth control, infertility and insulin.

This benefit includes Outpatient Injectable Medications and Self-Injectable Medication.

Mastectomy/Breast Reconstruction No copay

(After mastectomy and complications from mastectomy)

Newborn Care No copay

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.

Oral Surgery Services No copay

Paid at negotiated rate. Balance (if any) is your responsibility.

*After the Annual Medical Deductible has been met.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Network	
Radiation Therapy	
Complex	No copay
Standard (photon beam)	No copay
Reconstructive Surgery	No copay
Termination of Pregnancy	No copay
(Medical/medication and surgical).	
Vasectomy	No copay

*After the Annual Medical Deductible has been met.

Pharmacy Benefits

Pharmacy Plan Details					
Pharmacy Network		National			
Prescription Drug List		Advantage			
		In Network	Out of Network		
Annual Pharmacy Deductible					
Individual		You do not have to pay a pharmacy deductible			
Family		You do not have to pay a pharmacy deductible			
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 \$		\$5		
	Tier 2 \$\$		\$10		
	Tier 3 \$\$\$		\$15		
		\$25		\$30	
		\$50			

* 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 Tier1, Tier 2 or Tier 3.

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.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- 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.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product unless Prior Authorized.
- Any Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government except as otherwise provided by law.
- Any product dispensed for the purpose of appetite suppression or weight loss unless Prior Authorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory.
- Certain New Prescription Drug Products and/or new dosage forms that have not been reviewed for safety, efficacy and cost effectiveness unless Prior Authorized by UnitedHealthcare as Medically Necessary.
- Certain Prescription Drug Products for tobacco cessation unless they are FDA-approved tobacco cessation drugs and products.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available unless Medically Necessary.
- Certain compounded drugs, unless Prior Authorized as Medically Necessary by UnitedHealthcare.
- Diagnostic drugs used for diagnostic purposes.
- Dietary or nutritional products and food supplements including vitamins, except Prenatal vitamins, minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine.
- 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).
- Drugs available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay in a Hospital or Skilled Nursing Facility.
- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate.
- Experimental or Investigational drugs, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition) unless Medically Necessary and Prior Authorized by us.
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.

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.

توضيح: خدمات الترجمة متاحة للأشخاص الذين يتحدثون اللغة العربية (**Arabic**)، دون مقابل. يرجى الاتصال بالرقم المجاني المذكور على بطاقة هويتك. نأمل أن تكون بخير.

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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नशुल्क 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 kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shq'odí ninaaltsoos nítł'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodiilnih.

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 વગરના મૂલ્યે પ્રાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.