SignatureValue Alliance 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

Check out what's included in the plan	N/A
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 Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how SignatureValue Alliance 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.
Ped Dental Annual Deductible - Family	You do not have to pay a dental deductible
Ped Dental Annual Deductible - Individual	You do not have to pay a dental deductible

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

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

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	$3,500
Family	$7,000

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 *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 copy 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
Office Services - Sickness & Injury	
Allergy Testing and Treatment	
PCP Office Visit	$25 copay
Specialist Office Visit *Serum is covered.*	$50 copay
PCP/Other Practitioner Office Visits/Telehealth Services	$25 copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Specialist/Telehealth Services *Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services.*	$50 copay
Urgently Needed Services	
Urgent Care Services - outside medical group	$75 copay
Urgent Care Services - within medical group *Please consult your EOC for additional details.*	$25 copay
Virtual Care Services *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.*	No copay
Vision Refractions *For pediatric vision, please refer to your Vision Services Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.*	$25 copay
Emergency Care	
Emergency Ambulance	
Air Ambulance	$100 copay per transport
Ground Ambulance	$100 copay per transport
Emergency Services *The Co-payment is waived if admitted.*	$400 copay
Inpatient Care	
Hospital Benefits *Only one hospital Co-payment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Co-payment for that day.*	10%
Inpatient Rehabilitation and Habilitation Care *(Including physical, occupational and speech therapy)*	10%
Skilled Nursing Facility Care *Limited to 100 days per benefit period for Skilled Nursing Facility.*	10%
Outpatient Care	
Acupuncture Services	$10 copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Chiropractic Care *Limited to 20 visits of manipulative treatments per year.*	$15 copay
Home Health Care Visits *Limited to 100 visits per year.* *Limits are for services other than rehabilitation and habilitation. Home Health visits for rehabilitation up to a maximum of 100 visits per year. Home Health visits for habilitation up to a maximum of 100 visits per year. For infusion Therapy, a separate Infusion Therapy Co-payment applies per 30 days.*	$25 copay
Laboratory Services *When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply.*	$25 copay
Outpatient Habilitative Services and Outpatient Therapy	$25 copay
Outpatient Rehabilitation Services and Outpatient Therapy	$25 copay
Physician Care (physician fees)	10%
Radiology Services	
Specialized Scanning and Imaging Procedures	$200 copay
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.*	$25 copay
Surgery - Outpatient at a Network Free-Standing or Outpatient Surgery Facility	10%
Supplies and Services	
Durable Medical Equipment	$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 $2,000 per year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Limit includes repair/replacement.*	$70 copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Hearing Exam	
PCP Office Visit/Nonphysician Health Care Practitioner Office Visit	$25 copay
Specialist	$50 copay
Prosthetic and Corrective Appliances	$70 copay
Pregnancy	
Maternity Care	
Maternity Care - Inpatient	10%
Maternity Care, Tests and Procedures - PCP Office Visit	$25 copay
Maternity Care, Tests and Procedures - Specialist	$50 copay
Mental Health Care & Substance Related and Addictive Disorder Services	
All Other Outpatient Treatment *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 Supplement to the 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
Inpatient *Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.*	10%
Outpatient Office Visits	$25 copay
Other Services	
Bone Marrow Transplants	10%
Clinical Trials *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.
Cochlear Implant Devices *Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply.*	$50 copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Dental Treatment Anesthesia *Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply.* *Please refer to your Dental Supplement to the Combined Evidence of Coverage and Disclosure Form for pediatric dental benefits.*	$50 copay
Depo-Provera Medication (other than contraception) *Limited to 1 Depo-Provera injection every 90 days.* *Additional Co-payment for office visits may apply.*	$75 copay
Dialysis *Physician office visit Co-payment may apply.*	$50 copay
Home Test Kits for Sexually Transmitted Diseases	The amount you pay is based on where the covered health care service is provided.
Hospice Services - Inpatient *Prognosis of life expectancy of one year or less.*	10%
Hospice Services - Outpatient *Prognosis of life expectancy of one year or less.*	No copay
Infertility Services *If purchased by your employer, please refer to your Infertility Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.*	Not covered
Infusion Therapy *Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.*	$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)*	10%
Newborn Care *The inpatient hospital benefits Co-payment does not apply to newborns 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.*	10%
Oral Surgery Services	10%

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Radiation Therapy	
Complex	$200 copay
Standard (photon beam)	No copay
Reconstructive Surgery	10%
Specialized Footwear for Foot Disfigurement	$70 copay
Termination of Pregnancy *(Medical/medication and surgical).*	No copay
Vasectomy	No copay
Pediatric Services - Dental	
All Pediatric Dental - Benefits covered up to age 19 *Additional limits may apply. Refer to your plan documents for more information.*	
Basic Dental Services	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Diagnostic Services *Limited to 1 evaluation (checkup exam) every 6 months.* *Limited to 1 series of films every 6 months of Bitewing x-rays.* *Limited to 1 time every 36 months for Panoramic x-rays.*	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Major Restorative Services	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Medically Necessary Orthodontics[1] *All orthodontic treatment must be prior authorized.*	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Preventive Services *Limited to 1 dental prophylaxis cleaning and fluoride treatment every 6 months.*	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Pediatric Services - Vision	
Contact Lenses/Necessary Contact Lenses *Limited to 1 fitting and evaluation per year.* *Limited to a one year supply.* *We will pay benefits for only one vision care service. You may choose either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses.*	10%
Eyeglass Frames *Limited to once per year.*	10%

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Eyeglass Lenses *Limited to once per year.*	10%
Lens Extras *Limited to once per year.* *Coverage includes polycarbonate lenses and standard scratch-resistant coating.*	No copay
Low Vision Aids *Coverage includes high-power spectacles, magnifiers and telescopes.*	10%
Low Vision Testing *Limited to once every 24 months.*	No copay
Low Vision Therapy	10%
Routine Vision Exam *Limited to once per year.*	No copay
Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Custom Advantage (state mandated) w/ SMCS Drugs

	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

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail and Specialty Pharmacy Network**	**Retail Non-preferred Specialty Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 $	$5	Not applicable	$10
Tier 2 $$	$30	Not applicable	$60
Tier 3 $$$	$60	Not applicable	$120
Tier 4 $$$$	25% however you will not pay more than $250	Not applicable	25% however you will not pay more than $500
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Retail Non-preferred Specialty Network Pharmacy**	**Mail Order Preferred Specialty Network Pharmacy****
Tier 1 $	$5	$5	Not applicable
Tier 2 $$	$150	$150	Not applicable
Tier 3 $$$	$250	$250	Not applicable
Tier 4 $$$$	25% however you will not pay more than $250	25% however you will not pay more than $250	Not applicable

** 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.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to welcometouhc.com **> Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **SignatureValue Alliance** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com **> Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With myuhc.com®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Cosmetic Surgery
- Dental Care (Adult)
- 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 a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's 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 a mail order Network 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. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

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. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

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) 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, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. 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 a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network 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 a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions 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 Prescription Drug Product to the extent payment or benefits are provided by the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- 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, to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU) .
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain compounded drugs.
- Drugs available over-the-counter.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- 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. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Medications used for cosmetic or convenience purposes.
- Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Combined Evidence of Coverage and Disclosure Form.
- 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.

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