UnitedHealthcare®

Benefit Summary

Washington - Choice Plus
Balanced - Plan AM5F

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$25	$2,000	30%

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

UnitedHealthcare of Washington, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.

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

Medical Deductible - Individual	$2,000 per year	$6,000 per year
Medical Deductible - Family	$4,000 per year	$12,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	$6,850 per year	$20,550 per year
Out-of-Pocket Limit - Family	$13,700 per year	$41,100 per year

Your Costs

What is co-insurance?

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

What is a co-payment?

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

What is Prior Authorization?

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

Want more information?

Find additional definitions in the glossary at justplainclear.com.

*When Covered Health Services are provided as alternative care in lieu of hospitalization or institutionalization as described under Hospital - Inpatient Stay in Section 1 of the COC, Benefit limits stated in this Benefit Summary for Durable Medical Equipment, Home Health Care, Hospice Care, Rehabilitation Services - Outpatient Therapy and Manipulative Treatment, and Skilled Nursing Facility/Inpatient Rehabilitation Facility may not apply.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acupuncture Services		
Limited to 12 treatments per year. Benefits for acupuncture for the treatment of Chemical Dependency are not subject to the limit stated above.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Ambulance Services		
Emergency Ambulance:	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance:	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	30% co-insurance, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Cellular and Gene Therapy		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury. Prior Authorization is required.	Out-of-Network Benefits are not available.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician office Services - Sickness and Injury.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Services - Hospitalization and Anesthesia		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Physician Fees for Surgical and Medical Services; and Surgery - Outpatient.	
		Prior Authorization is required for Inpatient Stay.
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Physician Office Services - Sickness and Injury.	
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every year. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than $1,000.
Emergency Health Care Services - Outpatient		
	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
		Notification is required if confined in an Out-of-Network Hospital.
Formulas for Phenylketonuria (PKU)		
	30% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider.	50% co-insurance, after the medical deductible has been met or as stated under the Outpatient Prescription Drug Rider.
		Prior Authorization is required.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider. Benefits will be the same as those stated under Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or Reconstructive Procedures.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Manipulative Treatment. Speech therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. The limits stated above do not apply to Applied Behavioral Analysis or other therapy services for treatment of autism spectrum disorder diagnoses, subject to medical necessity and clinical appropriateness. The limits above do not apply to Neurodevelopmental therapy or other types of therapy which may be provided as treatment of autism spectrum disorder or other mental health diagnoses if the therapy is deemed medically necessary and appropriate.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient services.
Hearing Aids		
Limited to $5,000 every year. Benefits are further limited to a single purchase per hearing impaired ear every year. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
Limited to 130 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	30% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient:	30% co-insurance. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram services.
Major Diagnostic and Imaging - Outpatient		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Outpatient:	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain Inpatient, Outpatient and Partial Hospitalization/Intensive Outpatient Treatment services.
Neurodevelopment Therapy		
	$25 co-pay per visit for a primary care physician office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Ostomy Supplies		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	$25 co-pay per visit for a primary care physician office visit. A deductible does not apply. $55 co-pay per visit for a specialist office visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician Office Services - Sickness and Injury.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	Out-of-Network Benefits are not available.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
Limited to a single purchase of each type of prosthetic device every year. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Prosthetic Devices.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 20 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 20 visits of physical therapy. 20 visits of occupational therapy. 20 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. 20 visits of Manipulative Treatments. 20 visits of massage therapy. The limits stated above do not apply to Applied Behavioral Analysis or other therapy services for treatment of autism spectrum disorder diagnoses, subject to medical necessity and clinical appropriateness. The limits above do not apply to Neurodevelopmental therapy or other types of therapy which may be provided as treatment of autism spectrum disorder or other mental health diagnoses if the therapy is deemed medically necessary and appropriate.	$25 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Surgery - Outpatient		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Telemedicine Services		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.
Temporomandibular Joint (TMJ) Services		
	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient.	Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Benefits will be the same as those stated under Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury and Surgery - Outpatient. Prior Authorization is required.	Out-of-Network Benefits are not available.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	50% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.		
Urinary Catheters		
	30% co-insurance, after the medical deductible has been met.	50% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$10 co-pay per visit. A deductible does not apply.	Out-of-Network Benefits are not available.

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.

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

For Internal Use only:

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee 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.

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