Choice Plus 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	Choice Plus
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 Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$2,000	$4,000
Family	$4,000	$12,000

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	$5,000	$15,000
Family	$10,000	$30,000

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	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.* *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, co-insurance or deductible.*		No copay	Not covered
Office Services - Sickness & Injury			
Primary Care Physician *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work. Benefits for services provided by a Naturopathic Physician are included under the Complementary and Alternative Medicine category. Once limit is reached under Complemtary and Alternative Medicine section, Benefits under this category include services performed by a Naturopathic Physician.*	$20 copay	$35 copay	50%*

*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	Designated Network	Network	Out-of-Network
Specialist *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work. Benefits for services provided by a Naturopathic Physician are included under the Complementary and Alternative Medicine category. Once limit is reached under Complemtary and Alternative Medicine section, Benefits under this category include services performed by a Naturopathic Physician.*	$40 copay	$60 copay	50%*
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*		$50 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual 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.*		No copay	Not covered
Emergency Care			
Emergency Ambulance		20%*	20%*
Non-Emergency Ambulance[1]		20%*	20%*
Accidental Dental		20%*	20%*
Emergency Room[1]		20%*	20%*
Inpatient Care			
Congenital Heart Disease Surgeries[1]		20%*	50%*
Hospital Inpatient Stays[1]		20%*	50%*
Inpatient Habilitative Services[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services. These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*		The amount you pay is based on where the covered health care service is provided.	
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.* *For a head or spinal cord injury, benefits are limited to 60 days per year in an Inpatient Rehabilitation Facility.*		20%*	50%*

*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	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services *For outpatient therapies (physical therapy, occupational therapy, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services. These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*		$20 copay	50%*
Home Health Care[1] *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.*		20%*	50%*
Lab Testing			
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.		$25 copay	Not covered
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center. *Limited to 18 Presumptive Drug Tests per year.* *Limited to 18 Definitive Drug Tests per year.*		$50 copay	50%*
Major Diagnostic and Imaging[1]			
For services provided at a freestanding diagnostic center or in a physician's office.		20%*	50%*
For services provided at an outpatient hospital-based diagnostic center.		You pay a $350 per occurrence copay per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*	You pay a $350 per occurrence copay per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Physician Fees for Surgical and Medical Services			
Primary care visits	20%*	20%*	50%*
Specialist care visits	20%*	20%*	50%*

*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	Designated Network	Network	Out-of-Network
Rehabilitation Services *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *An additional 30 visits for severe neurologic conditions may be available when Medically Necessary. These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.*		$20 copay	50%*
Scopic Procedures For services provided at a freestanding center or in a physician's office. For services provided at an outpatient hospital-based center. *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		20%* You pay a $350 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*	50%* You pay a $350 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Surgery[1] For services provided at an ambulatory surgical center or in a physician's office. For services provided at an outpatient hospital-based surgical center.		20%* You pay a $350 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20%*	50%* You pay a $350 per occurrence copay per date of service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Therapeutic Treatments[1] *Therapeutic treatments include, but are not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.* *Out-of-Network Benefits are not covered for dialysis services.*		20%*	50%*

*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	Designated Network	Network	Out-of-Network
X-ray and other Diagnostic Testing[1]			
For services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.		$75 copay	50%*
For services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.		$100 copay	50%*
Supplies and Services			
Diabetes Self-Management and Training[1]		The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items[1]		The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Durable Medical Equipment, Orthotics and Supplies		20%*	Not covered
Enteral Nutrition		20%*	50%*
Hearing Aids *Limited to a single purchase per hearing impaired ear every three years (or more frequently if modifications to an existing hearing aid will not meet the needs of a Covered Person). Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Coverage includes up to one box of replacement batteries per year for each hearing aid.*		20%*	50%*
Ostomy Supplies		20%*	Not covered
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		20%*	50%*
Urinary Catheters		20%*	Not covered
Pregnancy			
Maternity Services[1] *Benefits for medically necessary treatments for a woman to manage her maternal diabetes from conception through six weeks post-partum is not subject to co-payments, co-insurance or annual deductibles. This applies to both Network and Out-of-Network 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.	
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*

*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	Designated Network	Network	Out-of-Network
Outpatient[1]		$20 copay	50%*
Partial Hospitalization[1]		20%*	50%*
Other Services			
Autism Spectrum Disorder - Medical Services[1] *Limited to 20 visits of occupational therapy.* *Limited to 20 visits of physical therapy.* *Limited to 20 visits of speech therapy.* *Treatment for Autism Spectrum Disorder - Medical Services is considered a mental health benefit. Such treatment encompasses problems associated with Autism Spectrum Disorder - Medical Services for which rehabilitative or habilitative services would be appropriate for Covered Persons.* *An additional 30 visits for severe neurologic conditions may be available when Medically Necessary. These visit limits are subject to medical necessity and will not apply to Autism Spectrum Disorder Services - Behavioral Services or Mental Health Care and Substance-Related and Addictive Disorders Services.*		The amount you pay is based on where the covered health care service is provided.	
Autism Spectrum Disorder Services - Behavioral Services Inpatient[1]		20%*	50%*
Autism Spectrum Disorder Services - Behavioral Services Outpatient[1]		$20 copay	50%*
Autism Spectrum Disorder Services - Behavioral Services Partial Hospitalization[1]		20%*	50%*
Cellular or 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.	Not covered
Clinical Trials[1]		The amount you pay is based on where the covered health care service is provided.	
Cochlear Implants[1]		The amount you pay is based on where the covered health care service is provided.	
Complementary and Alternative Medicine *Limited to $1,500 per year and also includes acupuncture, manipulative treatment and services by a naturopathic doctor.*		$20 copay	$20 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	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*		20%*	50%*
Gender Dysphoria[1]		The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hearing Assistive Technology Systems and Bone Conduction Sound Processors[1] *Benefits are available for hearing assistive technology systems for a Covered Person who is younger than 19 years of age, if necessary for appropriate amplification of hearing loss. Limited to a single purchase every three years.*		20%*	50%*
Hearing Loss Diagnostic and Treatment Services[1] *Benefits are available for necessary diagnostic and treatment services at least twice a year for Covered Persons who are younger than four years of age and at least once per year for Covered Persons who are four years of age or older.*		The amount you pay is based on where the covered health care service is provided.	
Hospice Care[1]		20%*	50%*
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*		20%*	50%*
Reconstructive Procedures[1]		The amount you pay is based on where the covered health care service is provided.	
Tobacco Use Cessation[1]		The amount you pay is based on where the covered health care service is provided.	
Telemedical Services[1]		The amount you pay is based on where the covered health care service is provided.	
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.	Not covered

*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	Designated Network	Network	Out-of-Network
Voluntary Sterilization Procedures for Men and Termination of Pregnancy[1]		No copay	50%*

*After the Annual Medical Deductible has been met.

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

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 **Choice Plus** 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 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.

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

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.

Underwritten by UnitedHealthcare Insurance Company.

Administrative services provided by United HealthCare Services, Inc. and their affiliates.

UnitedHealthcare®