UHC Doctors Plan EPO 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	Doctors Plan
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 Summary Plan Description (SPD), Riders, and/or Amendments, those documents govern. Review your SPD 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 Doctors Plan 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.
Annual Out-of-Pocket Limit	
Individual	$2,000 per year
Family	$4,000 per year

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.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Network
Preventive Care Services	
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.*	No copay
Office Services - Sickness & Injury	
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$25 copay
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$30 copay
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*	$25 copay

[1]Prior Authorization Required. Refer to SPD.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Virtual Care Services *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
Emergency Care	
Ambulance Services - Emergency Ambulance	$50 copay
Ambulance Services - Authorized Non-Emergency Ambulance	$50 copay
Dental Services - Accident Only	No copay
Emergency Health Care Services - Outpatient[1]	$100 copay
Inpatient Care	
Congenital Heart Disease (CHD) Surgeries	The amount you pay is based on where the covered health care service is provided.
Habilitative Services - Inpatient *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.
Hospital - Inpatient Stay	$200 copay
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Limited to 100 days per year.*	No copay
Outpatient Care	
Chiropractic Services *Limited to 30 visits per year.*	$15 copay
Habilitative Services - Outpatient *For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	$25 copay
Home Health Care *Limited to 100 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.*	$25 copay

[1]Prior Authorization Required. Refer to SPD.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing	No copay
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing	No copay
Major Diagnostic and Imaging - Outpatient	No copay
Physician Fees for Surgical and Medical Services	No copay
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Unlimited visits of cardiac rehabilitation therapy per year.* *Unlimited visits of post-cochlear implant aural therapy per year.* *Unlimited visits of pulmonary rehabilitation therapy per year.* *Unlimited visits of speech therapy per year.* *Unlimited visits of physical therapy, cognitive therapy and occupational therapy.*	$25 copay
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	No copay
Surgery - Outpatient	$100 copay
Therapeutic Treatments - Outpatient *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	No copay
Supplies and Services	
Diabetes Self-Management Items	The amount you pay is based on where the covered health care service is provided.
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.
Durable Medical Equipment (DME), Orthotics and Supplies	No copay
Enteral Nutrition	No copay

[1]Prior Authorization Required. Refer to SPD.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Hearing Aids *Limited to $2,500 per Covered Person, per hearing impaired ear, every 36 months.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	No copay
Ostomy Supplies	No copay
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	No copay
Prosthetic Devices	No copay
Urinary Catheters	No copay
Pregnancy	
Pregnancy - Maternity Services	The amount you pay is based on where the covered health care service is provided.
Mental Health Care & Substance Related and Addictive Disorder Services	
Inpatient	$200 copay
Outpatient	$25 copay
Partial Hospitalization	No copay
Other Services	
Acupuncture Services *Limited to 30 treatments per year.*	$15 copay
Cellular and Gene Therapy *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.
Clinical Trials	The amount you pay is based on where the covered health care service is provided.
Fertility Preservation for Iatrogenic Infertility[1] *This Benefit limit will be the same as, and combined with,those stated under Preimplantation Genetic Testing (PGT) andRelated Services. Benefits are further limited to one cycle offertility preservation for Iatrogenic Infertility per Covered Personduring the entire period of time he or she is enrolled forcoverage under the Agreement.*	No copay
Gender Dysphoria	The amount you pay is based on where the covered health care service is provided.

[1]Prior Authorization Required. Refer to SPD.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Hospice Care	No copay
Infertility Services *Up to six natural (intra-cervical) artificial inseminations, threestimulated (intra-uterine) artificial inseminations, and twocourses of gamete intrafallopian transfer (GIFT), zygoteintrafallopian transfer (ZIFT) or in vitro fertilization (IVF) perlifetime, and any related prescription medication treatment.*	50%
Obesity - Weight Loss Surgery *For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.
Preimplantation Genetic Testing and Related Services[1] *Benefit limits for related services will be the same as, andcombined 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 medicatioprovided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one AssistedReproductive Technology (ART) procedure during the entireperiod 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.*	No copay
Reconstructive Procedures	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.

[1]Prior Authorization Required. Refer to SPD.

Pharmacy Benefits

	In Network	
Annual Pharmacy Deductible		
Individual	You do not have to pay a pharmacy deductible	
Family	You do not have to pay a pharmacy deductible	

	In Network	
Annual Pharmacy Out-of-Pocket Limit		
Individual	See the Annual Medical Out-of-Pocket Limit section	
Family	See the Annual Medical Out-of-Pocket Limit section	

	Up to a 30-day supply	Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail Network**	**Mail Order Network Pharmacy**
Tier 1 $	$10	$20
Tier 2 $$	$25	$50
Tier 3 $$$	$50	$100
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Mail Order Preferred Specialty Network Pharmacy**
Tier 1 $	20% however you will not pay not more than $100	Not applicable
Tier 2 $$	20% however you will not pay not more than $100	Not applicable
Tier 3 $$$	20% however you will not pay not more than $100	Not applicable
Self Administered Drugs for Infertility	50%	50%

** Only certain Prescription Drug Products are available through mail order; please visit whyuhc.com/sfhss 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 30 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.

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 whyuhc.com/sfhss or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at whyuhc.com/sfhss > Benefits > Pharmacy Benefits.

Specialty medication cost share (SMCS) encourages you to talk to your doctor about lower cost medication options. You may pay more if you do not pick a lower cost option.

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 **whyuhc.com/sfhss > UnitedHealthcare Non-Medicare PPO/EPO Plans.**
- Choose **Search for a provider.**

Access your plan online.

With **whyuhc.com/sfhss,** 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 SPD, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Cosmetic Surgery
- Dental Care (Adult/Child)
- Experimental or Investigational or Unproven
- Glasses
- 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
- Wigs

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 30-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 Dispensing Entity.

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 whyuhc.com/sfhss 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 Dispensing Entity with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Dispensing Entity and you choose not to obtain your Prescription Drug Product from the Designated Dispensing Entity , you will be subject to the Out-of-Network Benefit for that Prescription Drug Product. Certain Preventative Care Medications may be covered at zero cost share. You can get more information by contacting us at whyuhc.com/sfhss or the telephone number on your ID card.

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Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Summary Plan Description for additional exclusions and limitations that may apply.

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless UnitedHealthcare Services, Inc. and the San Francisco Health Service System have agreed to cover.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the San Francisco Health Service System determines do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Compounded Prescription Drug Products that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that contain bulk powders. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product, or an over-the-counter drug and/or treatment for female contraception, and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.
- A Prescription Drug Product typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

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.

Plan Year: 01/01/2024-12/31/2024

UnitedHealthcare®