UnitedHealthcare Insurance Company of the River Valley
Attachment D - Schedule of Benefits

Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Deductible (calendar year)/(contract period)		
Individual	$3,250	$6,000
Family	$6,000	$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. The In-Network Deductible and Out-of-Network Deductible are separate.		
Maximum Out-of-Pocket Expense (calendar year)/(contract period) (includes Copayments, and Coinsurance, and Deductibles)		
Individual	$7,350	$14,700
Family	$14,700	$29,400
All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket Expense, but an individual will not have to pay more than the individual Maximum Out-of-Pocket Expense. The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate. Pharmacy cost sharing applies towards the Maximum Out-of-Pocket.		
4th Quarter Deductible Carryover	Not Applicable	Not Applicable

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Preventive Care Services *("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)*		
Physical Exams/Well-Child Care	Covered at 100%	50% of Allowed Charge after Deductible.
Immunizations	Covered at 100%	50% of Allowed Charge after Deductible.
Laboratory and X-ray	Covered at 100%	50% of Allowed Charge after Deductible.
Physician Office Services		
Office Visits	100% after you pay a Copayment of $50 PCP/$125 Specialist. Deductible does not apply.	50% of Allowed Charge after Deductible.
Office Surgery	100% after you pay a Copayment of $50 PCP/$125 Specialist. Deductible does not apply.	50% of Allowed Charge after Deductible.
Allergy Testing	100% after you pay a Copayment of $50 PCP/$125 Specialist. Deductible does not apply.	50% of Allowed Charge after Deductible.
Allergy Injections	80% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible.
Other Injections	80% of Allowed Charge. Deductible does not apply	50% of Allowed Charge after Deductible.
Maternity Physician Services	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Newborn Services		
Inpatient	*See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Outpatient	*See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Physician Services at a Facility other than the Office		
Home Visits	100% after you pay a Copayment of $50 PCP/$125 Specialist. Deductible does not apply.	50% of Allowed Charge after Deductible.
Inpatient Facility Visits	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Outpatient Facility Visits	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Inpatient Surgery (1)	80% of Allowed Charge after Deductible. You must first pay a Per Occurrence Deductible of $750 per visit.	50% of Allowed Charge after Deductible. You must first pay a Per Occurrence Deductible of $750 per visit.
Outpatient Surgery (1)	80% of Allowed Charge after Deductible. You must first pay a Per Occurrence Deductible of $350 per visit.	50% of Allowed Charge after Deductible. You must first pay a Per Occurrence Deductible of $350 per visit.
Emergency Services *(Follow-up care obtained in the emergency room is not covered.)*		
Emergency Room Physician	80% of Allowed Charge. Deductible does not apply.	Same as In-Network
Emergency Room	80% of Allowed Charge for initial care only of a Medical Emergency after Deductible Emergency Room Copayment waived if admitted. You must first pay a Per Occurrence Deductible of $500 per visit.	Same as In-Network
	Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.	
Urgent Care Facility	100% after you pay a Copayment of $50 per visit. Deductible does not apply.	50% of Allowed Charge after Deductible.
Ambulance Services	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**	80% of Allowed Charge after Deductible. **Non-emergency transports must be approved in advance by UnitedHealthcare.**
Laboratory, X-ray and Other Diagnostic Testing		
Outpatient	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Office	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Major Diagnostics (MRI, MRA, CAT and PET Scans) Outpatient	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible.
	Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.	
Chemotherapy, Radiation Therapy, Renal Dialysis Services		
Hospital (Outpatient)	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible
Office	80% of Allowed Charge. Deductible does not apply.	50% of Allowed Charge after Deductible.
Facility Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible.
Outpatient Facility	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Skilled Nursing Facility (2) - (*Member is limited to 100 days per calendar year/ contract period. The 100 In-Network and Out-of-Network days are combined.)*	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible.
Medical Equipment		
Durable Medical Equipment (2)	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Prosthetic Devices (2)	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Hearing Aid Devices (2) *(No dollar limits apply, and Plan covers a minimum of one hearing aid per ear every 36 months.)*	80% of Allowed Charge after Deductible.	Not covered
Outpatient Rehabilitative Therapy, Habilitative Services *Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) pulmonary rehabilitation, and habilitative services.*		
Limited per calendar year/ contract period as follows: • 36 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. *The below limits apply separately, when applicable, for rehabilitative and habilitative services:* • 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.	100% after you pay a Copayment of $50. Deductible does not apply.	50% of Allowed Charge after Deductible.
Spinal Manipulative Services	100% after you pay a Copayment of $50. Deductible does not apply.	50% of Allowed Charge after Deductible.
Home Health Services (2)	80% of Allowed Charge after Deductible.	Not covered.
Hospice Services (2)	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Respite Care (2)	80% of Allowed Charge after Deductible.	50% of Allowed Charge after Deductible.
Organ and Tissue Transplants (2)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	Not covered
Cornea Transplants	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	
Clinical Trials	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories*	
Gender Dysphoria	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services" or other applicable categories.*	

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.	100% after you pay a Copayment of $10 per visit Deductible does not apply.	50% of Allowed Charge after Deductible
Temporomandibular Joint Services (2)	*Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.*	
Mental Health Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility(2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services(2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per admission. Deductible does not apply.	50% of Allowed Charge after Deductible
Substance Abuse Services		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Facility(2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Outpatient Physician Services(2)	80% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of $50 per admission. Deductible does not apply.	50% of Allowed Charge after Deductible

Coverage Limitations:

(1) For services from Non-Participating Providers, the Allowed Charge is the Maximum Allowance. Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the Maximum Allowance for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

The Allowed Charge for Covered Services rendered by a Non-Participating Provider in a Medical Emergency will be determined as described in Section 1.1.2 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Provider's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.**

For both Inpatient Surgery and Outpatient Surgery, Covered Services provided by facility based Non-Participating Physicians in a Participating Hospital or facility will be paid at the In-Network benefit level, however the Allowed Charge will be determined as described in Section 1.1.3 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Physician's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense. In order to obtain the highest level of benefits, the Member should confirm whether a Physician is a Participating Physician prior to obtaining Covered Services.**

(2) Services require Preauthorization. When a Member uses Participating Providers, the Participating Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider). If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance. The Penalty amount paid by the Member will not exceed $1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.

When multiple Covered Health Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Health Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician's office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician's office Copayment, Coinsurance or Deductible.

UnitedHealthcare Insurance Company of the River Valley
Schedule of Benefits – Pediatric Dental and Vision

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider Out-of-Network
Pediatric Vision Care Services Deductible		
Individual	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Family	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Pediatric Dental Services Deductible		
Individual	Included in Annual Medical Deductible	Included in Annual Medical Deductible
Family	Included in Annual Medical Deductible	Included in Annual Medical Deductible

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider Out-of-Network
Pediatric Vision Services (Benefits covered up to age 19)		
You may access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.		
Routine Vision Examination *Benefits are limited to1 exam every year.*	100%. Deductible does not apply.	50% after Deductible
Eyeglass Lenses *Benefits are limited to once per year. Coverage includes polycarbonate lenses and standard scratch-resistant coating.*	100% after you pay a $25 copayment. Deductible does not apply.	50% after Deductible
Eyeglass Frames *Benefits are limited to once per year.*		
Eyeglass frames with a retail cost up to $130	100%. Deductible does not apply	50% after Deductible
Eyeglass frames with a retail cost of $130 - 160.	100% after you pay a $15 copayment. Deductible does not apply.	50% after Deductible
Eyeglass frames with a retail cost of $160 - 200.	100% after you pay a $30 copayment. Deductible does not apply.	50% after Deductible
Eyeglass frames with a retail cost of $200 - 250.	100% after you pay a $50 copayment. Deductible does not apply.	50% after Deductible
Eyeglass frames with a retail cost greater than $250.	60%. Deductible does not apply	50% after Deductible
Contact Lenses/Necessary Contact Lenses *Benefits are limited to a 12 month supply. Contacts are in lieu of Frames and Lenses. Reference www.myuhcvision.com for a complete list of covered contacts.*	100% after you pay a $25 copayment. Deductible does not apply.	50% after Deductible
Pediatric Dental Services (Benefits covered up to age 19)		
Preventive Services		
Dental Prophylaxis (Cleanings) *Benefit is limited to 2 times per 12 months.*	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.
Fluoride Treatments *Benefit is limited to 2 times per 12 months.*	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.
Sealants (Protective Coating) *Benefit is limited to once per first or second permanent molar every 36 months.*	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.
	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.
Diagnostic Services		
Evaluations (Check-up Exams) *Benefits are limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.*	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.
Radiographs *Benefits are limited to 2 series of films per 12*	100% of Allowed Charge. Deductible does not apply.	80% of Allowed Charge. Deductible does not apply.

Benefits for Covered Services	Participating Provider In-Network	Non-Participating Provider Out-of-Network
months. Limited to 1 time per 36 months for Complete/Panorex.		
Basic Dental Services		
Endodontics	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Adjunctive Services (Including Emergency treatment) Palliative Treatment: *Covered as a separate benefit only if no other service was done during the visit other than X-rays.* General Anesthesia: *Covered when clinically necessary.* Occlusal Guard: *Benefit is limited to 1 guard every 12 months and only covered if prescribed to control habitual grinding.*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Oral Surgery (including Surgical Extractions)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Periodontics Periodontal Surgery: *Benefit is limited to 1 quadrant or site per 36 months per surgical area.* Scaling and Root Planing: *Benefit is limited to 1 time per quadrant per 24 months.* Periodontal Maintenance: *Benefit is limited to 4 times per 12 months in combination with prophylaxis.*	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Restorations (Amalgam or Composite)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Major Restorative Services		
Inlays/Onlays/Crowns *Benefit is limited to 1 time per tooth per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Dentures and other removal Prosthetics *(Full denture/partial denture)* *Benefit is limited to 1 per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Fixed Partial Dentures (Bridges)	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Implants *Benefit is limited to 1 time per tooth per 60 months.*	60% of Allowed Charge after Deductible	50% of Allowed Charge after Deductible
Medically Necessary Orthodontics		
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.	60% of Allowed Charge after Deductible *Prior Authorization required for orthodontic treatment.*	50% of Allowed Charge after Deductible *Prior Authorization required for orthodontic treatment.*

UnitedHealthcare Insurance Company of the River Valley

Prescription Drug Benefits At-A-Glance

Benefit Features Member Responsibility

Your copayment is determined by the tier to which the Prescription Drug List 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.

Prescription Drug Products

Tier 1 .....$15 copayment
Tier 2 .....$75 copayment
Tier 3 .....$175 copayment
Tier 4 .....$300 copayment

Application of Drug Deductible Copayment

- Drug copayments for prescription drug products do not apply toward the medical deductible, but they do apply toward the medical maximum out-of-pocket expense
- You will be responsible for three copayments for each 90-day supply prescription fill or refill purchased at a retail pharmacy or by mail order.
- An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at the Member's or the provider's request that is Chemically Equivalent. An Ancillary Charge does not apply to any Annual Deductible or Out-of-Pocket Maximum.

Limitations

Prescription quantity shall be limited to the amount ordered by the attending physician. Quantity per prescription fill or refill shall not exceed a 31-day supply or such other day supply as authorized by UnitedHealthcare. However, items on the 90-day supply list may be dispensed in quantities up to a maximum of 90-day supply through retail pharmacy or by mail order. UnitedHealthcare reserves the right to establish criteria and require prior authorization for certain outpatient prescription drugs.

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. Supply limits apply to specialty prescription drug products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some prescription drug products or pharmaceutical products for which benefits are described under this prescription drug rider or Subscriber Agreement or Summary Plan Description are subject to step therapy requirements. This means that in order to receive benefits for such prescription drug products or pharmaceutical products you are required to use a different prescription drug product(s) or pharmaceutical product(s) first.

Also note that some prescription drug products require that you notify us in advance to determine whether the prescription drug product meets the definition of a covered service and is not experimental, investigational or unproven.

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 non-network benefit for that Prescription Drug Product.

Benefit Exclusions

Non-covered items include, but are not limited to: medications available over the counter (OTC), unless (1) such OTC medication has been designated by UnitedHealthcare as eligible for coverage as if it were an outpatient prescription drug, and (2) such OTC medication is obtained with a prescription from an attending physician • • therapeutic or prosthetic devices • drugs used for cosmetic purposes • drugs used to enhance physical or mental performance • certain treatment or supplies to promote smoking cessation • dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional formulas and supplements • general vitamins • medication for the treatment or enhancement of sexual performance or function • drugs used for treatment of infertility • drugs used for experimental purposes.

This document is provided as a brief summary and is not intended to be a complete description of the benefit plan. After you become covered, you will be issued a certificate of coverage (Subscriber Agreement or Summary Plan Description) describing your coverage in greater detail. The certificate of coverage will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this *Prescription Drug Benefits At-A-Glance*, and the certificate of coverage, the language of the certificate of coverage controls.

The company 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 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, 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 member toll-free phone number listed on your ID card.

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 other 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. ET.

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.

PAUNAWA: 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 **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

إذا كنت تتحدث اللغة **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية تتاح لك بيُرى. اتصل بالرقم المجاني الموجود 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。

توجگار زبل شم**فارسی (Farsi)** تلت، خدمات امداد زبلیبه طور رایگان در اختیارشما میباشد.لطفاًشمارهتفن رایگانی کووی کارتشناسایی شمدقیق شدهمراسبگیرید.

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 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.