



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit <http://content.carefirst.com/sbc/contracts/APPDB88ARXXDBJ8B.pdf>.

| Important Questions | Answers | Why this Matters: |
|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>What is the overall deductible?</p> | <p>In-Network: \$0; Out-of-Network: \$1,500 individual/ \$3,000 family.</p> | <p>Generally, you must pay all the costs from provider up to the deductible amount before this plan begins to pay. If you have other family member on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meet the overall family deductible.</p> |
| <p>Are there services covered before you meet your deductible ?</p> | <p>Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Diagnostic testing, Prescription drugs, Outpatient surgery, Emergency room, Emergency medical transportation, Urgent care, Inpatient hospital, Mental health services, Childbirth/delivery, Home health, Rehabilitation services, Skilled nursing, Durable medical equipment, Hospice.</p> | <p>This plan covers some items and services even if you haven't yet met the deductible amount. But, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>Yes. Pediatric Dental: In-Network: \$25 individual; Out-of-Network: \$50 individual. There are no other specific deductibles.</p> | <p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>Medical and Prescription Drug combined: In-Network: \$1,500 individual/ \$3,000 family.; Out-of-Network: \$3,000 individual/ \$6,000 family.</p> | <p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p> |

| | | |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.carefirst.com or call 1-855-258-6518 for a list of provider network . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do I need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|-------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Provider: \$10 copay per visit Hospital Facility: \$50 copay per visit | Provider: Deductible, then \$40 copay per visit Hospital Facility: Deductible, then \$150 copay per visit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Specialist visit | Provider: \$20 copay per visit Hospital Facility: \$50 copay per visit | Provider: Deductible, then \$40 copay per visit Hospital Facility: Deductible, then \$150 copay per visit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Retail Health Clinic | \$10 copay per visit | Deductible, then \$40 copay per visit | None |
| | Preventive care/screening/immunization | No Charge | Deductible, then No Charge | Some services may have limitations or exclusions based on your contract |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a test | Diagnostic test (x-ray, blood work) | LabTest: Non-Hospital: \$10 copay per visit Hospital: \$10 copay per visit XRay: Non-Hospital: \$20 copay per visit Hospital: \$20 copay per visit | LabTest: Non-Hospital: Deductible, then \$70 copay per visit Hospital: Deductible, then \$70 copay per visit XRay: Non-Hospital: Deductible, then \$70 copay per visit Hospital: Deductible, then \$70 copay per visit | None |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital: \$50 copay per visit Hospital: \$200 copay per visit | Non-Hospital: Deductible, then \$100 copay per visit Hospital: Deductible, then \$250 copay per visit | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rx | Generic drugs | \$10 copay | Paid As In-Network | For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 30-day supply; Up to 90-day supply of maintenance drugs is 2 copays; |
| | Preferred brand drugs | \$45 copay | Paid As In-Network | |
| | Non-preferred brand drugs | \$65 copay | Paid As In-Network | |
| | Preferred Specialty drugs | 50% of Allowed Benefit up to a maximum payment of \$100 | Not Covered | Specialty Drugs: Participating Providers: covered when purchased through the |
| | Non-preferred Specialty drugs | 50% of Allowed Benefit up to a maximum payment of \$150 | Not Covered | Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | Non-Hospital: \$50 copay per visit Hospital: \$150 copay per visit | Non-Hospital: Deductible, then \$150 copay per visit Hospital: Deductible, then \$250 copay per visit | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|----------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| surgery | Physician/surgeon fees | Non-Hospital & Hospital: \$20 copay per visit | Non-Hospital & Hospital: Deductible, then \$40 copay per visit | None |
| If you need immediate medical attention | Emergency room care | \$100 copay per visit | Paid As In-Network | Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted |
| | Emergency medical transportation | \$20 copay per visit | Paid As In-Network | Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency |
| | Urgent care | \$50 copay per visit | Paid As In-Network | Limited to unexpected, urgently required services |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$200 copay per admission | Deductible, then \$300 copay per admission | Prior authorization is required |
| | Physician/surgeon fee | \$20 copay per visit | Deductible, then \$40 copay per visit | None |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$10 copay per visit | Office Visit: Deductible, then \$40 copay per visit | For treatment at an Outpatient Hospital Facility, additional charges may apply |
| | Inpatient services | \$200 copay per admission | Deductible, then \$300 copay per admission | Prior authorization is required; Additional professional charges may apply |
| If you are pregnant | Office visits | No Charge | Deductible, then \$40 copay per visit | For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply. |
| | Childbirth/delivery professional services | \$20 copay per visit | Deductible, then \$40 copay per visit | None |
| | Childbirth/delivery facility services | \$200 copay per admission | Deductible, then \$300 copay per admission | Additional professional charges may apply |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|-----------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No Charge | Deductible, then \$40 copay per visit | Prior authorization is required; 90 visits/episode of care |
| | Rehabilitation services | Provider: \$20 copay per visit Hospital Facility: \$50 copay per visit | Provider: Deductible, then \$40 copay per visit Hospital Facility: Deductible, then \$150 copay per visit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Habilitation services | Provider: \$20 copay per visit Hospital Facility: \$50 copay per visit | Provider: Deductible, then \$40 copay per visit Hospital Facility: Deductible, then \$150 copay per visit | Prior authorization is required for Member age 21 and older; If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Skilled nursing care | \$20 copay per admission | Deductible, then \$40 copay per admission | Prior authorization is required; 60 days/benefit period |
| | Durable medical equipment | 25% of Allowed Benefit | Deductible, then 45% of Allowed Benefit | Prior authorization is required for specified services. Please see your contract. |
| | Hospice services | Inpatient Care: No Charge Outpatient Care: No Charge | Inpatient Care: Deductible, then \$40 copay per admission Outpatient Care: Deductible, then \$40 copay per visit | Prior authorization is required; For Participating Providers and Non-Participating Providers (combined): Limited to a maximum 180-day Hospice Eligibility Period which includes a maximum of 60 days Inpatient Hospice Services per Hospice Eligibility Period |
| If your child needs dental or eye care | Children's eye exam | No Charge | Member pays expenses in excess of the Pediatric Vision Allowed Benefit of \$40 | Limited to Members up to age 19; 1 visit/benefit period |
| | Children's glasses | No Charge for glasses/lenses | Allowances available for glasses/lenses | Limited to Members up to age 19; 1 set of glasses/lenses per benefit period |
| | Children's dental check-up | No Charge | 20% of Allowed Benefit | Limited to Members up to age 19; 2 visits/benefit period |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Abortion, except in limited circumstances
- Chiropractic care
- Coverage provided outside the United States. See www.carefirst.com
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|-----------------------------------------------------------------|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist Copayment | \$20 |
| ■ Hospital (facility) Copayment | \$200 |
| ■ Other Copayment | \$10 |

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$0 |
| Copayments | \$540 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$10 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Peg would pay is | \$550 |
|-----------------------------------|--------------|

Managing Joe's type 2 Diabetes
(a year of a routine in-network care of a well-controlled condition)

| | |
|-----------------------------------------------------------------|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist Copayment | \$20 |
| ■ Hospital (facility) Copayment | \$200 |
| ■ Other Coinsurance | 25% |

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|-------------|---------|
| Deductibles | \$0 |
| Copayments | \$1,035 |
| Coinsurance | \$370 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,405 |
|-----------------------------------|----------------|

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|-----------------------------------------------------------------|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist Copayment | \$20 |
| ■ Hospital (facility) Copayment | \$100 |
| ■ Other Copayment | \$20 |

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$0 |
| Copayments | \$260 |
| Coinsurance | \$63 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$323 |
|-----------------------------------|--------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address P.O. Box 8894
 Baltimore, Maryland 21224

Email Address civilrightscordinator@carefirst.com

Telephone Number 410-528-7820

Fax Number 410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ̀tílẹ̀ko: Àkíyèsí yíì ní iwífún nípa isẹ̀ adójútòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yíì àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòònù tó wà lẹ̀yìn káàdì idánimò wòn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tí tí a ó fì sọ̀ fún ọ̀ láti tẹ̀ 0. Nígbatí așojú kan bá dáhùn, sọ̀ èdè tí o fẹ̀ a ó sì sọ̀ ọ̀ pò mò ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawang ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsòò-wùdù (Bassa) Tò Dùù Cáó! Bǎ nǐà ké bá nyo bǎ ké m̄ gbo kpá bó nì fùà-fùá-tīn nyεε jè dyí. Bǎ nǐà ké bédé wé jéé bǎ bǎ m̄ ké dε wa m̄ m̄ ké nyuεε nyu hwè bǎ wé bǎa ké zi. Ǿ m̄ nì kpé bǎ m̄ ké bǎ nǐà ké kè gbo-kpá-kpá m̄ m̄ dε dyé dε nì bídí-wùdù mú bǎ m̄ ké se wídí d̄ò péè. Kpooò nyo bǎ m̄ dá fùùn-nòbà nǐà dε waa I.D. káàò dεín nyε. Nyo t̄òò séín m̄ dá nòbà nǐà ké: 855-258-6518, ké m̄ m̄ fò tee bǎ wa kéε m̄ gbo cǎ bǎ m̄ ké nòbà m̄à 0 kéε dyi pàdàìn hwè. Ǿ jǔ ké nyo d̄ò dyi m̄ gǔ jǔīn, po wuqu m̄ m̄ póε dyie, ké nyo d̄ò mu bó nìīn bǎ Ǿ ké nì wuquò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ سے: اس نوٹس میں آپ کے لئے ضروری معلومات کے بارے میں جانکاری دی گئی ہے۔ اس میں اہم تاریخیں اور آپ کے لئے ضروری اقدامات کے بارے میں بھی معلومات دی گئی ہیں۔ اگر آپ کو کسی بھی چیز کی ضرورت ہو تو براہ کرم اپنی زبان میں 855-258-6518 پر کال کریں اور آپ کو بہتر سہولتیں فراہم کی جائیں گی۔

فارسی (Farsi) توجه: این اطلاعیه حاوی اطلاعاتی بنواید که برای شما بسیار مهم است. ممکن است حاوی اطلاعاتی باشد که برای شما بسیار مهم است و الزاماً بر شما متعلق است. اگر شما از این حق برخوردار هستید، شما می توانید این اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. اگر شما به این درجه دسترسی ندارید، لطفاً به شماره 855-258-6518 تماس بگیرید و منتظر بمانید تا از شما خواسته شود عدد 0 را فشار دهید تا به شما دسترسی به خدمات بهتری داده شود.

العربية (Arabic) تنبيه: هذا إخطار علمي عن معلومات تتعلق بخدماتنا، وقد تحتوي على معلومات مهمة، وقد يحتاج إلى اتخاذ إجراء لتبسيط الإجراءات من أجل الحصول على الخدمة من أجل حصولك على هذه المعلومات. قد تحتاج إلى اتخاذ إجراء من أجل الحصول على هذه المعلومات. قد تحتاج إلى اتخاذ إجراء من أجل الحصول على هذه المعلومات. قد تحتاج إلى اتخاذ إجراء من أجل الحصول على هذه المعلومات.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'i'ígíí bá. Bii' dahólóq doo íiyisíí yoolkaálígíí dóo t'áadoo le'é ádadoolyííígíí da yókeedgo t'áa doo bee e'e'aaahí ájiil'ííh. Bee ná ahóót'i' díí bee íł hane' dóo níká'ádoowoł t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nitłizgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náánałta' éi kojí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį́ áádóo éi bikéé'dóo naasbaqas bił adidiilchíł. Áká'anidaalwó'ígíí neidiitáągo, saad bee yáníłt'i'ígíí yii diikił dóo ata' halne'é lá níká'ádoowoł.