CareFirst BlueChoice

BlueChoice Advantage Gold 1000

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or sample plan document at http://content.carefirst.com/sbc/contracts/AANMM77ARXXMMB7A.pdf or by logging into My Account.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network Providers: **$1,000** individual/**$2,000** family. Out-of-Network Providers: **$2,000** individual/**$4,000** family. Deductible does not apply to some services, including all In-Network Preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. For Pediatric Dental: **$25** for In-Network Providers; **$50** for Out-of-Network Providers. For Prescription Drug: **$250** per individual. There are no other specific **deductibles**.	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.
Is there an out-of-pocket limit on my expenses?	Yes. Medical and Prescription Drug combined: **$4,000** individual/**$8,000** family for In-Network Providers; **$8,000** individual/**$16,000** family for Out-of-Network Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.carefirst.com or call **1-855-258-6518** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Questions: If you are a member please call the number on your ID card or log into My Account. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: $15 copay per visit Hospital Facility: Deductible, then $50 copay per visit	Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: $30 copay per visit Hospital Facility: Deductible, then $50 copay per visit	Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Other practitioner office visit	Acupuncture: Provider: $30 copay per visit Hospital Facility: Deductible, then $50 copay per visit Chiropractic: Provider: $30 copay per visit Hospital Facility: Deductible, then $50 copay per visit	Acupuncture: Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit Chiropractic: Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply; 20 visits/condition/benefit period for Chiropractic
	Retail Health Clinic	$15 copay per visit	Deductible, then $50 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	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	LabTest: Non-Hospital: $15 copay per visit Hospital: Deductible, then $30 copay per visit XRay: Non-Hospital: $30 copay per visit Hospital: Deductible, then $60 copay per visit	LabTest: Non-Hospital: Deductible, then $65 copay per visit Hospital: Deductible, then $110 copay per visit XRay: Non-Hospital: Deductible, then $80 copay per visit Hospital: Deductible, then $110 copay per visit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: $200 copay per visit Hospital: Deductible, then $400 copay per visit	Non-Hospital: Deductible, then $250 copay per visit Hospital: Deductible, then $450 copay per visit	None
If you need drugs to treat your illness or condition **More information about <u>prescription drug coverage</u> is available at**	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; Specialty Drugs: Participating Providers: covered when purchased through the Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered
	Preferred brand drugs	Deductible, then $45 copay	Paid As In-Network	
	Non-preferred brand drugs	Deductible, then $65 copay	Paid As In-Network	
	Specialty drugs	Deductible, then 50% of Allowed Benefit up to a maximum payment of $150	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: $200 copay per visit Hospital: Deductible, then $300 copay per visit	Non-Hospital: Deductible, then $300 copay per visit Hospital: Deductible, then $400 copay per visit	None
	Physician/surgeon fees	Non-Hospital: $30 copay per visit Hospital: Deductible, then $30 copay per visit	Non-Hospital & Hospital: Deductible, then $50 copay per visit	None

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Deductible, then $250 copay per visit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Co-pay waived if admitted
	Emergency medical transportation	Deductible, then $30 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)	Deductible, then $400 copay per admission	Deductible, then $500 copay per admission	Prior authorization is required
	Physician/surgeon fee	Deductible, then $30 copay per visit	Deductible, then $50 copay per visit	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: $15 copay per visit	Office Visit: Deductible, then $50 copay per visit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Mental/Behavioral health inpatient services	Deductible, then $400 copay per admission	Deductible, then $500 copay per admission	Prior authorization is required; Additional professional charges may apply
	Substance use disorder outpatient services	Office Visit: $15 copay per visit	Office Visit: Deductible, then $50 copay per visit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Substance use disorder inpatient services	Deductible, then $400 copay per admission	Deductible, then $500 copay per admission	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Prenatal and postnatal care	No Charge	Deductible, then $50 copay per visit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Delivery and all inpatient services	Deductible, then $400 copay per admission	Deductible, then $500 copay per admission	Additional professional charges may apply
If you need help recovering or have	Home health care	No Charge	Deductible, then $50 copay per visit	Prior is authorization required

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
other special health needs	Rehabilitation services	Provider: $30 copay per visit Hospital Facility: Deductible, then $50 copay per visit	Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply; 30 visits/therapy type/condition/benefit period
	Habilitation services	Provider: $30 copay per visit Hospital Facility: Deductible, then $50 copay per visit	Provider: Deductible, then $50 copay per visit Hospital Facility: Deductible, then $100 copay per visit	Prior authorization is required; If a service is rendered at a Hospital Facility, the additional Facility charge may apply; Benefits available for Member age 19 and older are limited to 30 visits/therapy type/condition/benefit period
	Skilled nursing care	Deductible, then $30 copay per admission	Deductible, then $60 copay per admission	Prior authorization is required; 100 days/benefit period
	Durable medical equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract.
	Hospice service	Inpatient Care: No Charge Outpatient Care: No Charge	Inpatient Care: Deductible, then $50 copay per admission Outpatient Care: Deductible, then $50 copay per visit	Prior authorization is required
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 Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. See www.carefirst.com
- Termination of pregnancy, except in limited circumstances

Your Rights to Continue Coverage:

**** Individual Health Insurance --**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-258-6518. You may also contact your state insurance department at

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC - 1-877-685-6391 or www.disb.dc.gov
- Virginia - 1-877-310-6560 or www.scc.virginia.gov/boi

OR

**** Group Health Coverage --**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-258-6518. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: www.carefirst.com or 1-855-258-6518. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or http://www.mdinsurance.state.md.us
- DC - 1-877-685-6391 or www.disb.dc.gov
- Virginia - 1-877-310-6560 or www.scc.virginia.gov/boi

For group health coverage subject to ERISA you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijiho holne' 1-855-258-6518

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a Baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,095
- **Patient pays:** $1,445

Sample Care Costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$415
Coinsurance	$0
Limits or exclusions	$30
Total	**$1,445**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,672
- **Patient pays:** $1,728

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$480
Coinsurance	$248
Limits or exclusions	$0
Total	**$1,728**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.carefirst.com

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: If you are a member please call the number on your ID card or visit www.carefirst.com. Otherwise, please call 1-855-258-6518. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.carefirst.com/sbcg.

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	civilrightscoordinator@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 ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ 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) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ 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 nasasaklawan 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।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Ɖùǔ Cáo! Bɔ̃̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fṹà-fṹá-tììn nyɛɛ jè dyí. Bɔ̃̌ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwɛ̀ ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̃̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fṹùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃̌ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ́ ɔ ké nì wuɖuɔ̀ 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: یہ نوٹس آپ کے انشورنس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپکو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و الزم است تا تاریخ های مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی رایگان به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از اینکه یک نماینده پاسخگو بود، زبان مورد نیاز را ذکر کنید تا به مترجم مربوطه وصل شوید.

العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يُطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

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) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa 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 아니신 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 ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíłílígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.