



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/APNVBN0CRXXVBN2G.pdf>.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>In-Network: \$1,750 individual/ \$3,500 family; Out-of-Network: \$3,500 individual/ \$7,000 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(s) on the plan, each family member may need to meet their own individual deductible, OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.</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, Generic drugs, Outpatient surgery, Urgent care, Mental Health office visit, Home health, Rehabilitation services, 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. Prescription Drug: \$150 individual.</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: \$6,650 individual/ \$13,300 family; Out-of-Network: \$13,300 individual/ \$26,600 family.</p>	<p>The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, each family member may need to meet their own out-of-pocket limits, OR all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.</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: No Charge Hospital Facility: Deductible, then \$75 copay per visit	Provider: Deductible, then \$50 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; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Specialist visit	Provider: \$30 copay per visit Hospital Facility: Deductible, then \$75 copay per visit	Provider: Deductible, then \$50 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; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Retail Health Clinic	No Charge	Deductible, then \$50 copay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Preventive care/screening/immunization	No Charge	Deductible, then No Charge	Some services may have limitations or exclusions based on your contract; No member cost-sharing when services are rendered by an Indian Health Services Provider

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: \$15 copay per visit Hospital: Deductible, then \$60 copay per visit XRay: Non-Hospital: \$65 copay per visit Hospital: Deductible, then \$100 copay per visit	LabTest: Non-Hospital: Deductible, then \$65 copay per visit Hospital: Deductible, then \$150 copay per visit XRay: Non-Hospital: Deductible, then \$115 copay per visit Hospital: Deductible, then \$150 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Please see your contract. No member cost-sharing when services are rendered by an Indian Health Services Provider
	Imaging (CT/PET scans, MRIs)	Non-Hospital: \$250 copay per visit Hospital: Deductible, then \$350 copay per visit	Non-Hospital: Deductible, then \$300 copay per visit Hospital: Deductible, then \$400 copay per visit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply. Please see your contract. No member cost-sharing when services are rendered by an Indian Health Services Provider
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	No Charge	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 ordered via mail order only Non-Participating Providers: Not Covered
	Preferred brand drugs	Deductible, then \$50 copay	Paid As In-Network	
	Non-preferred brand drugs	Deductible, then \$70 copay	Paid As In-Network	
	Preferred Specialty drugs	Deductible, then \$100 copay	Not Covered	
	Non-preferred Specialty drugs	Deductible, then \$150 copay	Not Covered	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: \$300 copay per visit Hospital: Deductible, then \$400 copay per visit	Non-Hospital: Deductible, then \$400 copay per visit Hospital: Deductible, then \$500 copay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider

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: \$30 copay per visit Hospital: Deductible, then \$30 copay per visit	Non-Hospital & Hospital: Deductible, then \$50 copay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider
If you need immediate medical attention	Emergency room care	Deductible, then \$300 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; No member cost-sharing when services are rendered by an Indian Health Services Provider
	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; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Urgent care	\$50 copay per visit	Paid As In-Network	Limited to unexpected, urgently required services; No member cost-sharing when services are rendered by an Indian Health Services Provider
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then \$450 copay per day	Deductible, then \$550 copay per day	Prior authorization is required; Member maximum payment: Participating Provider: \$2,250 per admission; Non-Participating Provider: \$2,750 per admission; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Physician/surgeon fee	Deductible, then \$30 copay per visit	Deductible, then \$50 copay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge	Office Visit: Deductible, then \$50 copay per visit	For treatment at an Outpatient Hospital Facility, additional charges may apply; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Inpatient services	Deductible, then \$450 copay per day	Deductible, then \$550 copay per day	Prior authorization is required; Additional professional charges may apply; Member maximum payment: Participating Provider: \$2,250 per admission; Non-Participating Provider: \$2,750 per admission; No member cost-sharing when services are rendered by an Indian Health Services Provider
If you are pregnant	Office visits	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; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Childbirth/delivery professional services	Deductible, then \$30 copay per visit	Deductible, then \$50 copay per visit	No member cost-sharing when services are rendered by an Indian Health Services Provider
	Childbirth/delivery facility services	Deductible, then \$450 copay per day	Deductible, then \$550 copay per day	Member maximum payment: Participating Provider: \$2,250 per admission; Non-Participating Provider: \$2,750 per admission; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Home health care	No Charge	Deductible, then \$50 copay per visit	Prior authorization is required; 100 visits/benefit period; No member cost-sharing when services are rendered by an Indian Health Services Provider

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	Rehabilitation services	Provider: \$30 copay per visit Hospital Facility: Deductible, then \$75 copay per visit	Provider: Deductible, then \$50 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; 30 visits/benefit period; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Habilitation services	Provider: \$30 copay per visit Hospital Facility: Deductible, then \$75 copay per visit	Provider: Deductible, then \$50 copay per visit Hospital Facility: Deductible, then \$150 copay per visit	Prior authorization is required; If a service is rendered at a Hospital Facility, the additional Facility charge may apply; 30 visits/benefit period; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Skilled nursing care	Deductible, then \$75 copay per admission	Deductible, then \$150 copay per admission	Prior authorization is required; 100 days/admission; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required for specified services. Please see your contract; No member cost-sharing when services are rendered by an Indian Health Services Provider
	Hospice services	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; For Participating Providers and Non-Participating Providers (combined): Limited to a maximum of 180 days; No member cost-sharing when services are rendered by an Indian Health Services Provider
	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

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 your child needs dental or eye care	Children's glasses	No Charge	Member pays expenses in excess of the Pediatric Vision Allowed Benefit of \$110	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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Routine foot care 	<ul style="list-style-type: none"> • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Abortion, except in limited circumstances • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Coverage provided outside the United States. See www.carefirst.com • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult)

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: Virginia State Corporation Commission Bureau of Insurance, <http://www.scc.virginia.gov/boi/index.aspx>, or call 1-800-552-7945. 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: Virginia State Corporation Commission Bureau of Insurance, <http://www.scc.virginia.gov/boi/index.aspx>, or call 1-800-552-7945.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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](#).

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, kwijigo holne' 1-855-258-6518.

————— *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](#) \$1,750
- [Specialist Copayment](#) \$30
- Hospital (facility) [Copayment](#) \$450
- Other [Copayment](#) \$15

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 \$12,700

In this example, Peg would pay:

Cost Sharing

Deductibles	\$1,750
Copayments	\$900
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$10
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The total Peg would pay is \$2,660

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

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist Copayment](#) \$30
- Hospital (facility) [Copayment](#) \$450
- Other [Coinsurance](#) 20%

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 \$5,600

In this example, Joe would pay:

Cost Sharing

Deductibles	\$1,400
Copayments	\$650
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Joe would pay is \$2,050

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

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist Copayment](#) \$30
- Hospital (facility) [Copayment](#) \$300
- Other [Copayment](#) \$65

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 \$2,800

In this example, Mia would pay:

Cost Sharing

Deductibles	\$1,750
Copayments	\$260
Coinsurance	\$34

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is \$2,044

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 yíí ní iwífún nípa isẹ̀ adójútòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ojú gbèdẹ̀ke kan. O ni ètò láti gba iwífún yíí àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòònù tó wà lẹ̀yìn káàdì idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tí tí a ó fí 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 Cáo! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiìn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò dεín nyε. Nyò t̀òò séín m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa kέε m̄ gbo ćé b́é m̄ kè nòbà m̀òà 0 kέε dyi pàd̀àn hwè. Ǿ j̀ù kè nyò d̀ò dyi m̄ gǎ j̀ùìn, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nììn b́é Ǿ kè 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 ریشیوں سے کوئی ج سے نئے رقم و عمل و انتہا پر مشتمل ہے۔ اس سے پہلے کی دیکھاری تھی و سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنا پڑے آپ کے پاس یہ عمل و مات سے اور بھی خرچہ کیے ہیں یا ان میں سے کوئی بھی خرچہ کیا ہے۔ مہران کو بیلن شیٹ میں اضافی کارنگی کی پیشہ پر موجد و فونڈ پر کال کرنے سے پہلے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 ٹیپ کر کے جواب دینے سے پہلے ہی ملے گا۔

فارسی (Farsi) توجه: این اطلاعیه حاوی اطلاعاتی بنواید که به شما در مورد پوشش بیمه شما ملحق است. ممکن است حاوی تاریخ های مهمی باشد و الزامات مشخصاتی مقرر شده مخصوص شما باشد. شما از طریق بر خوردار مسیبتات این اطلاعات و رافقی ربه صورت رنگاربه زبان خودتان دریافت کنید. اعضا بطلب شما درجه شده در پیش تکارتشن اسلی شانت ماسیگی بند. سر رفلر ادیح تو لب با شما در 855-258-6518 ماسیگی بند و انتظار بمانت از لها خواست شود عدد 0 رفلر ار دق دبعد اپاسخ گی ویتوس طیک ای پراتور ها، زبان موردی از رلقظ کفیتا به بترجم میوطه وصل شود.

العربية (Arabic) تنبيه: هذا إخطار عمومي لعموم انتبش أبت غطت كالت أبتة، وبتحتوي على إيت وإوخ مهمة، وقت ضاجال يثخاذا إجراء اتبجول مواج دن هبة محدة ي حقل كالحصول على هذلمس اعدقوالم عمل و انتبش غابدونت حمل أبتشفة مبنغ غي على أعضاء لكصال على رقم ال هتفالم ذك ورفي ظه رب طبق غي فال هبة أخاص قبهم يمكن أل خرون لكصال عمل طلرقم 855-258-6518 ال بظار خلال الم حلة ضي وطلب في هلبض غط على رقم 0 وبت ابعلة أحتل و كلاء، اذ كلال غة لك يث ضاجال ال تواصل لبها وسيت متواصل لكب أحت ال بتر جم ال فوهن.

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 ekwenti di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahụ 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 ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'i' díí bee íł hane' dóo níká'ádoowot t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'i' hodoonihjí'. Aadóo náánáta' éi kojí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį áádóo éi bikéé'dóo naasbaqas bił adidiilchit. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'i'ígíí yii diikił dóo ata' halne'é lá níká'ádoowot.