

# BluePreferred PPO Gold 1500 Ded Summary of Benefits

Non-Integrated Deductible

| Services                                                                                                                                                                                                                                                     | In-Network You Pay <sup>1</sup>                                                                                                                                                                   | Out-of-Network You Pay <sup>1</sup>                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Visit <a href="http://www.carefirst.com/doctor">www.carefirst.com/doctor</a> to locate providers and facilities                                                                                                                                              |                                                                                                                                                                                                   |                                                                  |
| <b>24-HOUR NURSE ADVICE LINE</b>                                                                                                                                                                                                                             |                                                                                                                                                                                                   |                                                                  |
| Free advice from a registered nurse. Visit <a href="http://www.carefirst.com/needcare">www.carefirst.com/needcare</a> to learn more about your options for care.                                                                                             | When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.                                                          |                                                                  |
| <b>WELLBEING PROGRAM &amp; BLUE REWARDS</b>                                                                                                                                                                                                                  |                                                                                                                                                                                                   |                                                                  |
| Visit <a href="http://www.carefirst.com/sharecare">www.carefirst.com/sharecare</a> for more information.                                                                                                                                                     | You have access to a comprehensive wellbeing program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities. |                                                                  |
| <b>ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)<sup>2,3</sup></b>                                                                                                                                                                                              |                                                                                                                                                                                                   |                                                                  |
| Individual/Family                                                                                                                                                                                                                                            | \$1,500 Individual/\$3,000 Family (separate)                                                                                                                                                      | \$3,000 Individual/\$6,000 Family (separate)                     |
| <b>ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)<sup>2,4,5</sup></b>                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                  |
| Individual/Family                                                                                                                                                                                                                                            | \$6,200 Individual/\$12,400 Family (separate)                                                                                                                                                     | \$12,400 Individual/\$24,800 Family (separate)                   |
| <b>PREVENTIVE SERVICES</b>                                                                                                                                                                                                                                   |                                                                                                                                                                                                   |                                                                  |
| Well-Child Care (including exams & immunizations)                                                                                                                                                                                                            | No charge*                                                                                                                                                                                        | No charge*                                                       |
| Adult Physical Examination (including routine GYN visit)                                                                                                                                                                                                     | No charge*                                                                                                                                                                                        | No charge* after deductible                                      |
| Breast Cancer Screening                                                                                                                                                                                                                                      | No charge*                                                                                                                                                                                        | No charge*                                                       |
| Pap Test                                                                                                                                                                                                                                                     | No charge*                                                                                                                                                                                        | No charge*                                                       |
| Prostate Cancer Screening                                                                                                                                                                                                                                    | No charge*                                                                                                                                                                                        | No charge*                                                       |
| Colorectal Cancer Screening                                                                                                                                                                                                                                  | No charge*                                                                                                                                                                                        | No charge* after deductible                                      |
| <b>PCP AND SPECIALIST SERVICES</b>                                                                                                                                                                                                                           |                                                                                                                                                                                                   |                                                                  |
| FACILITY CHARGE <sup>6</sup> —In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2) | Deductible, then \$50 per visit                                                                                                                                                                   | Deductible, then \$150 per visit                                 |
| Office Visits for Illness—PCP <sup>6,7</sup>                                                                                                                                                                                                                 | \$15 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Office Visits for Illness—Specialist                                                                                                                                                                                                                         | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Allergy Testing <sup>6</sup>                                                                                                                                                                                                                                 | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Allergy Shots <sup>6</sup>                                                                                                                                                                                                                                   | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Physical, Speech, and Occupational Therapy <sup>6</sup>                                                                                                                                                                                                      | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Chiropractic <sup>6</sup>                                                                                                                                                                                                                                    | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Acupuncture <sup>6</sup>                                                                                                                                                                                                                                     | \$40 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| <b>IMMEDIATE AND EMERGENCY SERVICES</b>                                                                                                                                                                                                                      |                                                                                                                                                                                                   |                                                                  |
| Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)                                                                                                                                                             | \$15 per visit                                                                                                                                                                                    | Deductible, then \$50 per visit                                  |
| Urgent Care Center <sup>8</sup> (such as Patient First or ExpressCare)                                                                                                                                                                                       | \$50 per visit                                                                                                                                                                                    | Deductible, then \$150 per visit                                 |
| Hospital Emergency Room Services <sup>8</sup>                                                                                                                                                                                                                |                                                                                                                                                                                                   |                                                                  |
| ■ Facility                                                                                                                                                                                                                                                   | Deductible, then \$350 per visit (waived if admitted)                                                                                                                                             | In-network deductible, then \$350 per visit (waived if admitted) |
| ■ Physician                                                                                                                                                                                                                                                  | Deductible, then \$40 per visit                                                                                                                                                                   | In-network deductible, then \$40 per visit                       |
| Ambulance (if medically necessary) <sup>8</sup>                                                                                                                                                                                                              | Deductible, then \$40 per service                                                                                                                                                                 | In-network deductible, then \$40 per service                     |

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| Services                                                                                                                           | In-Network You Pay <sup>1</sup>         | Out-of-Network You Pay <sup>1</sup>     |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|
| <b>DIAGNOSTIC SERVICES</b>                                                                                                         |                                         |                                         |
| Labs                                                                                                                               |                                         |                                         |
| ■ Non-Hospital/Freestanding Facility                                                                                               | \$15 per visit                          | Deductible, then \$65 per visit         |
| ■ Hospital                                                                                                                         | Deductible, then \$30 per visit         | Deductible, then \$110 per visit        |
| X-ray                                                                                                                              |                                         |                                         |
| ■ Non-Hospital/Freestanding Facility                                                                                               | \$30 per visit                          | Deductible, then \$80 per visit         |
| ■ Hospital                                                                                                                         | Deductible, then \$60 per visit         | Deductible, then \$110 per visit        |
| Imaging                                                                                                                            |                                         |                                         |
| ■ Non-Hospital/Freestanding Facility                                                                                               | \$200 per visit                         | Deductible, then \$250 per visit        |
| ■ Hospital                                                                                                                         | Deductible, then \$400 per visit        | Deductible, then \$450 per visit        |
| <b>SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)</b>                                  |                                         |                                         |
| Outpatient Surgery (Non-Hospital)                                                                                                  |                                         |                                         |
| ■ Facility                                                                                                                         | \$200 per visit                         | Deductible, then \$300 per visit        |
| ■ Physician                                                                                                                        | \$40 per visit                          | Deductible, then \$50 per visit         |
| Outpatient Surgery (Hospital)                                                                                                      |                                         |                                         |
| ■ Facility                                                                                                                         | Deductible, then \$300 per visit        | Deductible, then \$400 per visit        |
| ■ Physician                                                                                                                        | Deductible, then \$40 per visit         | Deductible, then \$50 per visit         |
| Inpatient Surgery and Hospital Services                                                                                            |                                         |                                         |
| ■ Facility                                                                                                                         | Deductible, then \$400 per admission    | Deductible, then \$500 per admission    |
| ■ Physician                                                                                                                        | Deductible, then \$40 per visit         | Deductible, then \$50 per visit         |
| <b>HOSPITAL ALTERNATIVES</b>                                                                                                       |                                         |                                         |
| Home Health Care<br>(limited to 90 visits per episode of care)                                                                     | No charge*                              | Deductible, then \$50 per visit         |
| Hospice<br>(Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period) | No charge*                              | Deductible, then \$50 per visit         |
| Skilled Nursing Facility<br>(limited to 60 days/benefit period)                                                                    | Deductible, then \$400 per admission    | Deductible, then \$500 per admission    |
| <b>MATERNITY</b>                                                                                                                   |                                         |                                         |
| Preventive Prenatal and Postnatal Office Visits                                                                                    | No charge*                              | Deductible, then \$50 per visit         |
| Delivery and Facility Services                                                                                                     | Deductible, then \$400 per admission    | Deductible, then \$500 per admission    |
| Artificial and Intrauterine Insemination <sup>6,9</sup>                                                                            | Not covered                             | Not covered                             |
| In Vitro Fertilization Procedures <sup>6,9</sup>                                                                                   | Not covered                             | Not covered                             |
| <b>MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)</b>                     |                                         |                                         |
| Office Visit                                                                                                                       | No charge*                              | Deductible, then \$50 per visit         |
| Outpatient Services                                                                                                                |                                         |                                         |
| ■ Facility                                                                                                                         | No charge*                              | Deductible, then \$50 per visit         |
| ■ Physician                                                                                                                        | No charge*                              | Deductible, then \$50 per visit         |
| Inpatient Services                                                                                                                 |                                         |                                         |
| ■ Facility                                                                                                                         | Deductible, then \$400 per admission    | Deductible, then \$500 per admission    |
| ■ Physician                                                                                                                        | Deductible, then \$30 per visit         | Deductible, then \$50 per visit         |
| <b>MEDICAL DEVICES AND SUPPLIES</b>                                                                                                |                                         |                                         |
| Durable Medical Equipment                                                                                                          | Deductible, then 25% of Allowed Benefit | Deductible, then 45% of Allowed Benefit |
| Hearing Aids                                                                                                                       | Not covered                             | Not covered                             |

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| Services                                                                                                                                                   | In-Network You Pay <sup>1</sup>                                                                                                            | Out-of-Network You Pay <sup>1</sup>     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| PRESCRIPTION DRUGS <sup>10,11</sup>                                                                                                                        |                                                                                                                                            |                                         |
| Formulary List                                                                                                                                             | Visit <a href="http://www.carefirst.com/acarx">www.carefirst.com/acarx</a> to locate Formulary List                                        |                                         |
| Annual Prescription Drug Deductible                                                                                                                        | \$250 per person<br>(waived for generic drugs; preferred and non-preferred brand insulin)                                                  |                                         |
| Preventive Drugs                                                                                                                                           | No charge*                                                                                                                                 |                                         |
| Diabetic Supplies                                                                                                                                          | No charge*                                                                                                                                 |                                         |
| Oral Chemo Drugs and Medication Assisted Treatment Drugs                                                                                                   | No charge*                                                                                                                                 |                                         |
| Generic Drugs                                                                                                                                              | 30-day supply \$10;<br>90-day supply \$20 (maintenance drugs only)                                                                         |                                         |
| Preferred Brand Drugs <sup>12</sup> (Preferred Insulin \$0)                                                                                                | 30-day supply Deductible, then \$45;<br>90-day supply Deductible, then \$90 (maintenance drugs only)                                       |                                         |
| Non-preferred Brand Drugs <sup>13</sup> (Non-preferred Insulin capped at \$30 for 30 days/\$60 for 90 days)                                                | 30-day supply Deductible, then \$65;<br>90-day supply Deductible, then \$130 (maintenance drugs only)                                      |                                         |
| Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)                                                                    | 30-day supply Deductible, then 50% up to \$100 maximum;<br>90-day supply Deductible, then 50% up to \$200 maximum (maintenance drugs only) |                                         |
| Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)                                                                | 30-day supply Deductible, then 50% up to \$150 maximum;<br>90-day supply Deductible, then 50% up to \$300 maximum (maintenance drugs only) |                                         |
| PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)                                                                    |                                                                                                                                            |                                         |
| Routine Exam (limited to 1 visit/benefit period)                                                                                                           | No charge*                                                                                                                                 | Total charge minus \$40 reimbursement   |
| Frames and Contact Lenses—Pediatric Collection Only                                                                                                        | No charge*                                                                                                                                 | Reimbursements apply                    |
| Spectacle Lenses                                                                                                                                           | No charge*                                                                                                                                 | Reimbursements apply                    |
| PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)                                                                    |                                                                                                                                            |                                         |
| Annual Dental Deductible                                                                                                                                   | \$25                                                                                                                                       | \$50                                    |
| Class I Preventative & Diagnostic Services—Exams, cleanings, fluoride treatments, sealants, bitewing x-rays <sup>14</sup> , full mouth x-ray <sup>15</sup> | No charge*                                                                                                                                 | 20% of Allowed Benefit                  |
| Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics                                                     | Deductible, then 20% of Allowed Benefit                                                                                                    | Deductible, then 40% of Allowed Benefit |
| Class III Major Services—Surgical periodontics, endodontics, oral surgery                                                                                  | Deductible, then 20% of Allowed Benefit                                                                                                    | Deductible, then 40% of Allowed Benefit |
| Class IV Major Services—Restorative Crowns, dentures, inlays and onlays                                                                                    | Deductible, then 50% of Allowed Benefit                                                                                                    | Deductible, then 65% of Allowed Benefit |
| Class V Medically Necessary Orthodontic Services                                                                                                           | 50% of Allowed Benefit                                                                                                                     | 65% of Allowed Benefit                  |

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Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges \$100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept \$50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to \$50.

\* No copayment or coinsurance.

- 1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
- 2 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
- 3 Separate - For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
- 4 Separate - For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.
- 5 All drug costs are subject to the in-network out-of-pocket maximum.
- 6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
- 7 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.
- 8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
- 9 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.
- 10 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
- 11 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
- 12 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
- 13 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.
- 14 Class I Preventative & Diagnostic Services-Exams, cleanings, fluoride treatments, sealants, bitewing x-rays are limited to 2 per year per provider per location.
- 15 Class I Preventative & Diagnostic Services-Full mouth x-ray is limited to 1 per every 3 years per provider per location.

**Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.**

The benefits described are issued under form numbers: DC/CF/SHOP/GC (R. 1/19); DC/CF/SHOP/PPO/EOC (R. 1/23); DC/GHMSI/DOL APPEAL (R. 1/22); DC/CF/SHOP/PPO/DOCS (R. 1/23); DC/CF/BP PPO/GOLD 1500 (1/24); DC/CF/BLCRD (R. 6/18); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/NO SURP ACT/AMEND (R. 1/23); DC/CF/2024 GC AMEND (1/24); DC/CF/SHOP/PPO/2024 AMEND (1/24); DC/CF/SG/AUTH AMEND/PPO (R. 1/24); DC/CF/PT PROTECT (9/10); DC/GHMSI - HEALTH GUARANTY 5/21; DC/CF/SG/INCENT (R. 1/23); DC/CF/SHOP/ELIG (R. 1/21) and any amendments.



CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SUM6734-1P (9/23) ■ DC ■ 2024 2-50 ACA Compliant



# Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits 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<br>Baltimore, Maryland 21224                                                            |
| Email Address    | <b><a href="mailto:civilrightscoordinator@carefirst.com">civilrightscoordinator@carefirst.com</a></b> |
| 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>**.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



## 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 ይችላል። ይኸን 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 ሲሰጥ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

**Èdè Yorùbá (Yoruba) Ìtètíléko:** Àkíyèsí yíí ní iwífún nípá isẹ̀ adójútòfò rẹ̀. Ó lẹ̀ ní àwọn déèti pàtó o sì lẹ̀ ní láti gbé igbésẹ̀ ní àwọn ojò gbèdéke kan. O ni ètò láti gba iwífún yíí àti irànlówó ní èdè rẹ̀ lófèfẹ̀. Àwọn ọmọ-egbé gbòdò pe nọmbà fòònù tò wà lẹyin káàdì idánimọ̀ wọn. Àwọn mírán lẹ̀ pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tíítí a ó fí sọ fún ọ̀ láti tẹ̀ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì sọ ọ̀ pọ̀ mọ̀ 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 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। यह जानकारी आपको यह जानकारी और संबंधित सलाह अपनी भाषा में तनःशुल्क पाने का अधिकार है। सदस्यों को अपने पचान पत्र के पीछे हटाए गए फोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के ललए न कल जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएं और आपको व्याख्याकार से कनेक्ट कर हदया जाएगा।



Bàsòò-wùdù (Bassa) Tò Ìdù Cá! Bǎ nǎ kɛ bá nyo bɛ kɛ m̃ gbo kpá bó nì fù à-fúá-tiín nyɛɛ jè dyí. Bǎ nǎ kɛ bédé wé jéé bɛ bɛ m̃ kɛ dɛ wa mó m̃ kɛ nyuɛɛ nyu hwɛ bɛ wé bɛa kɛ zi. ɔ mò nì kpé bɛ m̃ kɛ bǎ nǎ kɛ kɛ gbo- kpá-kpá m̃ m̃ɛɛ dyé dɛ nì bídí-wùdù mú bɛ m̃ kɛ se wídí dɔ péé. Kpooò nyo bɛ m̃ dǎ fúún-nòbà nǎ dɛ waà I.D. káàò dɛín nyɛ. Nyo tòò séín m̃ dǎ nòbà nǎ kɛ: 855-258-6518, kɛ m̃ m̃ fò tee bɛ wa kɛɛ m̃ gbo ɛɛ bɛ m̃ kɛ nòbà mòà 0 kɛɛ dyi pàdàin hwɛ. ɔ jǔ kɛ nyo dɔ dyi m̃ gǎ jǔín, po wuɖu m̃ mó poɛ dyɛ, kɛ nyo dɔ mu bó nìin bɛ ɔ kɛ nì wuɖuò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নন্যাটিশি আপনার ববমা কভারজ সম্পর্কে তথ্য রশশো। এর মশযয গুরুত্বপূর্বে তাবরখ থাকশত পাশর এবাং বনবদম্বেট তাবরশখর মশযয আপনাশক পদশক্ক্ষপ বনশত হশত পাশর। ববনা খরশে বনশজর ভাষা এই তথ্য পাওরে এবাং সহাতো পাওরে অবযকার আপনার আশো। সদসযশদরশক তাশদর পবরপেশরে বপশেন থাকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টপিশত না বনা পন্নুত অশপক্ক্ষা করশত পাশরনা। রখন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলুন এবাং আপনাশক নদাভাযীর সশে সাংরুক্ত করা হশব।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو 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 لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را 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 پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة 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 المساعدة والمعلومات بلغتك بدون 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 يطلب 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證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 kwesiri 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 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Dine Bizaad (*Navajo*) Ge': Dif bee it hane'igif bii' dahéáQ bee eedahézin beeso ach' h naanil nik'ist'i'fgii ba. Bii' dahéáQQ doo fiyisif yoolkaaligif déé t'aadoo le'e adadoolyililigii da yékeedgo t'aa doo bee e'e'aahi ajiil'íih. Bee na ahéét'i' dii bee it hane' déé nika'adoowot t'aa nfnizaad bee t'aa jiik'e. Atah danilinigif beesh bee hane'e bee wétta'igif nitt'izgo bee nee hédolzinfgif bikeed , bikaa' bich'l' hodoonihjǫ́'. Aadéé naanata' ef kojł' dahédoolnih íęęęęęęęęęę déé yii diitts'łłt yattł'łgif t'aa nflełjǫ́ aadéé ef bikee'déé naasbc;ác;ás bit adidiilchit. Aka'anidaalwé'fgif neidiit go, saad bee yanitt'i'fgif yii diikit déé ata' halne'e la nfka'adoolwot.

