

Notice of Privacy Practices

As a participant in a health plan offered by Prince George's County Public Schools (PGCPS), you are entitled under federal law to receive a privacy notice that describes how the health plan may use and disclose your health information. The privacy notice describes how a health plan is permitted and required to use and disclose your health information and provides a description of your rights and the health plan's obligations under federal and state privacy laws.

A privacy notice for the PGCPS Benefits Plan, available to each PGCPS employee and retiree covered by the PGCPS Board Sponsored benefits plan, follows. A summary of the provision in the notice is outlined below:

How a health plan may use and disclose your health information

A health plan is permitted to use and disclose your health information for a number of different purposes. In some cases, you are entitled to object to such uses and/or disclosures and in other cases you are not entitled to object to certain uses and disclosures of your health plan. If a health plan wants to use or disclose your health information for a purpose not stated in the privacy notice, it may obtain your written authorization before it can use or disclose your health information. A health plan may use and disclose your information

- to pay for your health care treatment,
- to perform business management and general administrative activities,
- to law enforcement officials,
- for health oversight activities, and
- to avert a serious threat to the health or safety of an individual

Please refer to the following privacy notice for a complete listing of the purposes for which health plan is permitted to use and disclose your health information.

Your Rights as a Participant in a Health Plan

Pursuant to federal law, you have a number of rights associated with your health information. Your rights include to:

- restrict or limit how a health plan uses or discloses your health information,
- request confidential communications, inspect and copy your health information,
- inspect and copy your health information,
- amend your health information,
- an accounting of disclosures, and
- receive a paper copy of the privacy notice.

Obligations of a Health Plan

A plan is required to provide you with a privacy notice and comply with its terms. However, a plan may amend the privacy notice and apply such amendment to all of the health information it maintains.

Contact Information

A detailed privacy notice follows. Please read it carefully. If you have any questions or require additional information about the privacy notice, please contact the Benefits Services Department at 301-952-6200 or pgcps.benefits@pgcps.org.

Privacy notice for Prince George's County Public Schools Employee Benefits Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice describes how the self-insured components of the PGCPSP Benefits Services Department, may use and disclose your health information to carry out treatment, payment and health care operations and for the other uses that are required or permitted by law. The self-insured components include the health, dental, prescription drug, and vision benefits for which PGCPSP is the plan sponsor. Each of these self-insured components is referred to in this Privacy Notice as a "Health Plan". Additionally, this Privacy Notice explains the rights you have with respect to your health information, and certain obligations the Benefits Services Department must abide by in accordance with the law.

Each health plan is required by law to maintain the privacy of your health information and provide you with this privacy notice outlining the health plan's legal duties and privacy practices with respect to your health information. Nothing contained in this privacy notice should be construed to supersede or limit any additional rights you may be entitled to under other applicable laws. Therefore, if an applicable law affords you greater rights or more protections other than as described herein, each health plan will comply with the law that gives you greater rights and/or procedures.

Each health plan is required to abide by the terms of this privacy notice, but reserves the right to make additional changes of this privacy notice and to make such changes applicable to all your health information that such health plan maintains. If the Benefits Services Department makes any material revisions to this privacy notice, it will provide you with a copy of the revised privacy notice, which will specify the date on which such revised privacy notice becomes effective.

I. Use and Disclosure of Your Health Information

A health plan in which you are enrolled may use your health information for treatment, payment, and health care operations. A health plan also may use your health information for other purposes that are permitted

and/or required by law and pursuant to your written authorization. The following lists examples of how a health plan may use and/or disclose your health information. Any other uses not described in this privacy notice will only be made with your explicit written authorization, which authorization you may revoke at any time by providing written notice of your revocation.

II. Your Rights as a Participant in a Health Plan

As a participant in one or more of the health plans, you have a number of rights associated with your health information. The following describes your specific rights.

A. The Right to Request a Restriction or Limitation on the Use and Disclosure of Your Health Information

You have the right to request restrictions or limitations on how a health plan is allowed to use and/or disclose your health information; however, the health plan does not have to agree to your requested restriction or limitation. If you would like to request a restriction or limitation on a health plan's use or disclosure of your health information, please send your request in writing to the address listed at the end of this privacy notice. Your request must specify – (1) if you would like to restrict or limit health plan's use, disclosure, or both; (2) what information you would like to restrict or limit; and (3) to whom you want the limitation or restriction to apply (e.g., your spouse).

If a health plan agrees to a restriction or limitation of your health information, the restriction or limitation will not prevent such health plan from disclosing your health information as follows: (1) to you if you request access to your health information or if you request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to worker's compensation); or (3) in the case of an emergency, as described below.

If a health plan accepts your restriction or limitation regarding how such health plan may use or disclose your health information, the health plan may

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nevertheless disclose the restricted health information to a health care provider if you are in need of emergency care and your restricted health information is needed to provide emergency treatment to you. Before the health plan discloses your restricted health information to a health care provider during an emergency, the health plan will request that the health care provider that receives your health information not further use or disclose your health information.

If a health plan accepts your requested restriction or limitation, such health plan may terminate the restriction or limitation if – (1) you agree to the termination or request the termination in writing; (2) you orally agree to the termination and the oral agreement is appropriately documented; or (3) the health plan informs you that it is terminating the restriction or limitation provided, however, the health plan's termination would only be effective for health information the health plan creates or receives after the health plan informs you of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations

You have the right to request receipt of health information from a health plan by alternative means or via alternative locations provided that you clearly state that the disclosure of all or part of your health information could endanger you. For example, you may want to receive communications related to your health care at a different address other than your home address because you could be in danger of harm if someone at that address saw such health information. If you wish to receive confidential communications via alternative means or locations, please submit your request to the address listed at the end of this privacy notice and set forth the alternative means by which you wish to receive communications or the alternative location at which you wish to receive such communications. A health plan will accommodate all reasonable requests.

C. Right to Access your Health Information

You have the right of access to inspect and obtain a copy of your health information provided, however, you are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding;

and (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA) to the extent that the provision of access to the individual would be prohibited by law or is exempt from CLIA. To access your health information, please send your request in writing to the address listed at the end of this privacy notice. If a health plan does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. If you request a copy of your health information, you will receive a response to your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, a health plan may deny your request for access to health information. Unreviewable grounds for denial are: situations involving (i) psychotherapy notes, information compiled for use in legal proceedings, and certain information held by clinical laboratories; (ii) certain requests which are made by inmates of correctional institutions; (iii) information created or obtained during research that includes treatment if certain conditions are met; (iv) denials permitted by the Privacy Act, 5 U.S.C. § 524a; and (v) information obtained from non-health care providers pursuant to promises of confidentiality. See 45 C.F.R. 164.524(a)(2).

Reviewable grounds for denial are: (i) disclosures which would cause endangerment of the individual or another person; (ii) situations where the protected health information refers to another and disclosure is likely to cause substantial harm; and (iii) requests made by a personal representative where disclosure is likely to cause substantial harm. See C.F.R. § 164.524(a)(3). If access is ultimately denied, you will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of disclosures of your health information made by a health plan, including disclosures to or by business associates of the health plan, for the period of six (6) years prior to the date on which you request an accounting of disclosures or such lesser period as you indicate provided, however, you are not entitled to receive an accounting of disclosures for disclosures that occurred prior to April 14, 2003. If you wish to

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receive an accounting of disclosures, please send your written request to the address listed at the end of this privacy notice. If a health plan does not have your health information in its possession, it will provide you with the appropriate contact information when it receives your request. You will receive a response to your request for an accounting of disclosures no later than 60 days after your request is received.

Notwithstanding the foregoing, your accounting of disclosures will not include any disclosures made – (1) to carry out treatment, payment, and/or health care operations; (2) directly to you; (3) incident to a use or disclosure otherwise permitted by law; (4) pursuant to your authorization; (5) to persons involved in your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2003.

You will receive one request annually free of charge and, thereafter, a health plan may charge you a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same 12 month period. A health plan will notify you of the cost for an accounting of disclosures and you may choose to withdraw or modify your request before you are charged any costs.

E. Right to Amend Your Health Information

If you believe a health plan has health information about you that is incorrect or incomplete, you may make a written request to the health plan stating the reasons to support your requested amendment. You have the right to request an amendment to your health information for as long as the health plan maintains your health information. If you would like to make a request to amend your health information, please send your request in writing to the address listed at end of this privacy notice. If the health plan does not have your health information in its possession, it will provide you with the appropriate contact information when your request is received. You will receive a response to your request for an amendment no later than 60 days after the health plan receives your request. However, a health plan may deny your request for amendment if, for example, the health plan determines your requested health information was not created by such health plan or is already accurate

and complete. You may respond to the denial by filing a written statement of disagreement. The health plan has the right to rebut your disagreement. If this occurs, you have the right to request that your original request, the denial, your statement of disagreement, and the rebuttal be included in future disclosures of your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice

You have the right at any time to obtain a paper copy of this privacy notice, even if you receive this privacy notice electronically. If you have received an electronic copy of this privacy notice, but wish to obtain a paper copy of this privacy notice, please send your written request to the address listed at the end of this privacy notice.

III. Miscellaneous

A. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. If you wish to file a complaint with the Benefits Services Department, please forward your written complaint to the address listed at the end of this privacy notice. If you choose to file a complaint, Prince George's County Public Schools is prohibited by law from retaliating against you for filing such complaint.

B. Effective Date

This notice is effective as of August 2014.

C. Contact Information

If you need any additional information about this privacy notice, please contact the EEO Advisor for Prince George's County Public Schools.

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

Èdè Yorùbá (Yoruba) Ìtẹ̀tílẹ̀ko: Àkíyèsí yíì ní iwífún nípa isẹ̀ adójútòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé igbésẹ̀ ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yíì àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòònù tó wà lẹ̀yìn káàdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò 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-tiĩn 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 kè gbo-kpá-kpá m̄ ḿεε dyé d́é nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ d́á fúùn-nòb̀à nìà d́é waa I.D. káàò d́éin nyε. Nyò t̀òò séin m̄ d́á nòb̀à nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa ḱε m̄ gbo ćé b́é m̄ kè nòb̀à m̀òà 0 ḱε dyi pàd̀àn hwè. Ǿ j̀ù kè nyò d̀ò dyi m̄ g̀ǎ j̀ùĩn, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nìin 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) یہ نوٹس آپ کے ارٹھیں س کوئی ج سے نئےلقم عملوم انتہر مشتمل ہے۔ اس ہیکلہدفاری میں و سیکٹی میں اور مکن ہے کہ آپکو مخصوص آخریتای خوتیک کارروئی کین کی ضرورت پڑے آپ کے پاسیہ عملومات حاصل کینے اور بیغی خرچہ کی بیلی زبان میں مدد حاصل کینے کا حق ہے۔ مہران کو بیلی نیشن اضی کارگی کش تہر موج وفون ن ہپر کال کینے چھوے۔ سبھی فگر لوگ 855-258-6518 پر کیکا کر سکتے ہیں اور 0 ٹیپلے کو کسے جلے تک نظر کیں ای جنٹکے جواب میں پیریلی طلبہ زبان بتھیں اور تہرجم سے مہبوط ہو چھوے گے۔

فارسی (Farsi) (توجہ: ظن اع یہ حاوی اط تعلی نیوارہ پوش شہیمی شاملت. مکن لرت حاوی ت ایخ ای مہمی سبتک ایخ مقرر شدہ مخصی قلم کیند. شما از طریق بر خوردار مسیہ تا ظن اط عات و راق طلی رلبہ صورت رنگار بہ زبان خوتان دفت کیند. اعضا بلایا شماره درج شدہ درپش تکارتشن اسلی شانت ماسیگی نند. سرلرفلر ادھی تو لبجا شماره 855-258-6518 ماسیگی نند و تہ نظر بلانہ تا از لہا نخواست مشود عدد 0 فلشار دق دبعد اپاسخ گی یتوس طکی ایپراتور ہا، زبان موردی از رلقظ کھیتا بہ تہرجم مہبوطہ وصل شود.

العربیة (Arabic) تنبیہ جتوي هذا خطر على عمال وم انتبش أنت غطت كالت أوفية، وقدحتوي على ت واوخ مہمہ، قیت ضا جالی یكخ اذ إجراء اتسبح لول مواجی دن ہنہ مہددة ی حق لك الحصول على ہذلل مس اعدقو الم عمل و انتبلی غا كبدونت حمل ألیشفة مین غی علی عضاء اتصال علی رقم الہتفالم ذكوفی ظہر بطقیت خی فالھی فالخاص قہم یمكن ین اتصال علی ظلرقم 855-258-6518 تظار خ لال محلیتہ ضی وطلب فی ہللیض غط علی رقم 0. ہجد اہجلا حطوك، اذ كلال غة لك یت ضا جالی التواصل لہا وسیت متوصل لك بأحد اللہر جہال فوہن.

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

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

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

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

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

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aahee ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól 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'í' hodoonihjí'. Aadóo náána'á' éí kójjí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį́ áádóo éí bikéé'dóo naasbaqas bił adidiilchil. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowól.