

| Product Name | BlueChoice HMO Open Access | BlueChoice Advantage | |
|---|--|---|--|
| Services | You Pay | In-Network You Pay | Out-of-Network You Pay |
| NETWORK | BlueChoice | BlueChoice and Preferred Provider (PPO Blue Card) | Participating/Non-Participating |
| PER VISITS | \$10 PCP / \$20 Specialist per visit | \$20 PCP / \$20 Specialist | N/A |
| ANNUAL DEDUCTIBLE | | | |
| Individual | \$0 | \$250 | \$500 |
| Individual & Child | \$0 | \$500 | \$1,000 |
| Individual & Adult | \$0 | \$500 | \$1,000 |
| Family | \$0 | \$500 | \$1,000 |
| ANNUAL OUT-OF-POCKET LIMIT | | | |
| Medical | \$2,000 Individual / \$6,000 Family | \$1,000 Individual / \$2,000 Family | \$1,000 Individual / \$2,000 Family |
| Prescription Drug | \$4,600 Individual / \$7,200 Family | \$5,600 Individual / \$11,200 Family | \$5,600 Individual / \$11,200 Family |
| LIFETIME MAXIMUM BENEFIT | Unlimited except on fertility services | Unlimited except on fertility services | |
| PREVENTIVE SERVICES | | | |
| Well-Child Care | | | |
| 0–24 months | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| 24 months–13 years (immunization visit) | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| 24 months–13 years (non-immunization visit) | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| 14–17 years | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| Adult Physical Examination | \$0 per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| Routine GYN Visits | \$0 per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| Prostate Screening | \$0 per visit | \$0 per visit | \$0 per visit |
| Other Cancer Screening (Mammogram, Pap Test and Colorectal) | \$0 per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| OFFICE VISITS, LABS AND TESTING | | | |
| Office Visits for Illness | \$10 PCP / \$20 Specialist per visit | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| Diagnostic Services | \$10 PCP / \$20 Specialist per visit | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| X-ray and Lab Tests | No per visit (LabCorp) | \$0 per visit (LabCorp) | After deductible is met, 20% of CareFirst member cost |
| Allergy Testing | \$10 PCP / \$20 Specialist per visit | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| Allergy Shots | \$10 PCP / \$20 Specialist per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| Allergy Serum | \$10 PCP / \$20 Specialist per visit | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| Outpatient Physical, Speech and Occupational Therapy (Office Setting) | \$20 per visit; (limited to 100 visits per therapy/per year) | \$20 per visit—Physical, Speech and Occupational Therapy (limited to 100 visits per therapy/per year) | After deductible is met, 20% of CareFirst member cost (limited to 100 visits per therapy/per year) |
| Outpatient Chiropractic | \$20 per visit; (limited to 20 visits per condition/per year) | \$20 per visit (unlimited visits) | After deductible is met, 20% of CareFirst member cost (unlimited visits) |
| EMERGENCY CARE AND URGENT CARE | | | |
| Physician’s Office | \$10 PCP / \$20 Specialist per visit | \$20 per visit | \$20 per visit |
| Urgent Care Center | \$20 per visit | \$20 per visit | \$20 per visit |
| Hospital Emergency Room | \$75 per visit (waived if admitted) | \$100 per visit (waived if admitted) | \$100 per visit (waived if admitted) |
| Ambulance (if medically necessary) | \$0 per visit | \$0 per visit | \$0 per visit |

| Product Name | BlueChoice HMO Open Access | BlueChoice Advantage | |
|---|--|--|---|
| Services | You Pay | In-Network You Pay | Out-of-Network You Pay |
| HOSPITALIZATION | | | |
| Inpatient Facility Services | \$0 | \$0 after deductible | After deductible is met, 20% of CareFirst member cost |
| Outpatient Facility Services | \$0 per visit | \$35 per visit | After deductible is met, 20% of CareFirst member cost |
| Inpatient Physician Services | \$0 | \$0 | After deductible is met, 20% of CareFirst member cost |
| Outpatient Physician Services | \$0 per visit | \$25 per visit | After deductible is met, 20% of CareFirst member cost |
| HOSPITAL ALTERNATIVES | | | |
| Home Health Care | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| Hospice | \$0 per visit | \$0 per visit | 20% of CareFirst member cost |
| Skilled Nursing Facility (limited to 365 days/benefit period) | \$0 | \$0 | After deductible is met, 20% of CareFirst member cost |
| MATERNITY | | | |
| Prenatal and Postnatal Office Visits | \$0 per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| Delivery and Facility Services | \$0 | \$0 | After deductible is met, 20% of CareFirst member cost |
| Nursery Care of Newborn | \$0 | \$0 | After deductible is met, 20% of CareFirst member cost |
| Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth) | 50% of CareFirst member cost | \$20 per visit (office) | After deductible is met, 20% of CareFirst member cost |
| InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth & \$100,000 lifetime max) | 50% of CareFirst member cost | \$20 per visit (office) | After deductible is met, 20% of CareFirst member cost |
| MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—SUBJECT TO FEDERAL MANDATE | | | |
| Inpatient Facility Services (requires Pre-authorization) | \$0 | \$0 after deductible | After deductible is met, 20% of CareFirst member cost |
| Inpatient Physician Services | \$0 | \$0 | After deductible is met, 20% of CareFirst member cost |
| Outpatient Services (MH & SA) | \$10 per visit | \$20 per visit (office) | After deductible is met, 20% of CareFirst member cost |
| Partial Hospitalization | \$0 per visit | \$35 per visit | After deductible is met, 20% of CareFirst member cost |
| Medication Management Visit | \$10 per visit | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| MISCELLANEOUS | | | |
| Durable Medical Equipment | \$0 per visit | \$0 per visit | After deductible is met, 20% of CareFirst member cost |
| Acupuncture | Not covered | \$20 per visit | After deductible is met, 20% of CareFirst member cost |
| Transplants—Major Organ | \$0 per visit. Travel & Lodging limited to 90 days per transplant | \$0 per visit. Travel & Lodging limited to 90 days per transplant | |
| Hearing Aids for Children and Adults (limited to one hearing aid/ per ear every 36 months) | \$0 per aid/per ear; member may be balanced billed up to the total charge | \$0 per aid/per ear; member may be balanced billed up to the total charge | \$0 per aid/per ear; member may be balanced billed up to the total charge |
| VISION* | BlueVision Plus is an option for both the HMO and BlueChoice Advantage plans. | | |
| PRESCRIPTION DRUGS | \$10 Generic / \$20 Preferred Brand / \$35 Non-preferred Brand / 50% up to \$75 max. Preferred Specialty / 50% up to \$150 max. Non-preferred Specialty; Mail Order included—Formulary 2 | \$10 Generic / \$20 Preferred Brand / \$35 Non-preferred Brand / 50% up to \$75 max. Preferred Specialty / 50% up to \$150 max. Non-preferred Specialty; Mail Order included—Formulary 2 | |
| DEPENDENT AGE LIMIT | To age 26, end of month | To age 26, end of month | |

| Product Line | Standard Group Over 65 | |
|--|--|---|
| Services | Medicare Covers | Standard Group Over 65 |
| Part A Hospital Deductible | 60 days of inpatient hospital care, except for a \$1,676 deductible. | Pays the first \$1,676 of the inpatient hospital bill for the first 60 days of hospitalization. |
| Inpatient Days 61–90 | 30 additional days of hospital inpatient care, except for a \$419 per day copay. | Pays the \$419 per day copay for days 61–90 of inpatient hospitalization. |
| Lifetime Reserve Days | 60 additional “lifetime reserve” days of inpatient hospital care, except for a \$838 per day copay. | Pays \$838 per day copay when the 60 “lifetime reserve” days are used. |
| Skilled Nursing Facility | 100 days of inpatient care in a skilled nursing facility, except for the \$209.50 per day copay for days 21–100. | Pays the \$209.50 per day copay for days 21–100 in a skilled nursing facility. |
| Inpatient Medical/Surgery | 80% of the Medicare-approved amount for in-hospital surgery and medical care, after the annual \$257 deductible has been met. | Pays the \$257 deductible and 20% of the Medicare-approved amount for in-hospital surgery and medical care. |
| Outpatient Surgery | 80% of the Medicare-approved amount for outpatient hospital visits and surgery, for medical conditions after the annual \$257 deductible has been met. | Pays the \$257 deductible and 20% of the Medicare-approved amount for outpatient hospital visits and surgery, for a medical condition.* |
| Emergency Services | 80% of the Medicare-approved amount for minor surgery and emergency first aid provided in a physician's office or hospital outpatient department, after the annual \$257 deductible has been met. | Pays the \$257 deductible and 20% of the Medicare-approved amount for physician services for surgery and emergency first aid provided in a physician's office or hospital outpatient department.* |
| Diagnostic Services | Covers clinical laboratory services at 100% of the Medicare-approved amount. 80% of the Medicare-approved amount for diagnostic X-rays or pathology examinations provided in a physician's office or hospital outpatient department, after the \$257 deductible has been met. | Medicare covers in full. For outpatient minor surgery or accidental injury: Pays the \$257 deductible and 20% of the Medicare-approved amount if provided by a Medicare participating physician or hospital outpatient department* For all other cases: Covered by Major Medical. |
| Radiation/Chemotherapy Services | 80% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department, after the \$257 deductible has been met. | Pays the \$257 deductible and 20% of the Medicare-approved amount for radiation/chemotherapy services provided in an office or hospital outpatient department. |
| Diabetic Self-Management | 80% of the Medicare-approved amount for blood glucose monitors, testing strips, lancet devices, after the \$257 annual deductible has been met. | Pays 80% of Medicare Part B deductible and coinsurance. |
| PREVENTIVE SERVICES | | |
| Annual Physical | One Annual Wellness visit every 12 months. There is no coinsurance, copay or deductible. | Covered by Medicare |
| Routine GYN | No coinsurance, copay or deductible for Pap Smears, Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women at high risk. | 100% of the Allowed Benefit the year Medicare does not pay |
| Prostate Cancer Screening Exam | 80% of the Medicare-approved amount for digital rectal exam for men age 50 and older after the \$257 annual deductible has been met. 100% for the PSA test; 80% for other related services. Covered once a year. | Pays 100% of Medicare Part B deductible and coinsurance. |
| Colorectal Cancer Screening Procedures | No coinsurance, copay or deductible for screening colonoscopy or screening flexible sigmoidoscopy. | Covered by Medicare |
| Mammography Screening | No coinsurance, copay or deductible. One baseline between ages 35–39. Once every 12 months for age 40 and older. | Covered by Medicare |
| Bone Mass Measurement | No coinsurance, copay or deductible. Once every 24 months for persons at high risk for osteoporosis. | Covered by Medicare |

*Benefits limited to minor surgery or services provided within 72 hours of an accident or injury.

In addition to the Standard Group Over 65 Benefits, the Retirees of Commissioners of St. Mary’s County, Metropolitan Commission and Library also have:

- Major Medical Benefits to reimburse subscribers for out-of-pocket expenses not covered by Medicare, such as balances on office visits and durable medical equipment. Major Medical benefits are then reimbursed at 80% of allowed benefit up to \$500 out-of-pocket maximum. Reimbursement is then 100% of allowed benefit for the remaining calendar year.
- Prescription Drug Card Program—Generic \$10 / Preferred Brand \$20 / Non-Preferred Brand \$35 / Preferred Specialty 50% up to \$75 max. / Non-preferred Specialty 50% up to \$150 max. / Mail Order included—Formulary 2
The prescription annual out-of-pocket maximum is \$6,100

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

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 14858 Lexington, KY 40512 |
| 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>.

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 identification card. All others may call 1-855-258-6518 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.

ማሳሰቢያ (Amharic):- ይህ ማሳወቂያ ስለ ኢንሹራንስ ሽፋንዎ መረጃ ይካተታል። ቁልፍ ቀኖችን ሊይዝ ይችላል እና በተወሰኑ የግዜ ገደቦች እርምጃ መውሰድ ሊኖርብዎ ይችላል። ይህን መረጃ እና እገዛ ያለ ምንም ወጪ በቋንቋዎ የማግኘት መብት አለዎት። አባላት በአባላት መታወቂያ ካርዳቸው ጀርባ ወዳለው ስልክ ቁጥር መደወል አለባቸው። ሌሎች በሙሉ ወደ 855-258-6518 በመደወል 0ን እንዲጫኑ እስኪጠየቁ ድረስ ምልልሱን መጠበቅ ይችላሉ። አንድ ወኪል ሲመልስ፣ የሚፈልጉትን ቋንቋ ይግለጹ እና ከአስተርጓሚ ጋር ይገናኛሉ።

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هوية العضوية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-6518 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

মনোযোগ দিন (Bengali): এই বিজ্ঞপ্তিতে আপনার বীমা কভারেজ সম্পর্কে তথ্য রয়েছে। এতে গুরুত্বপূর্ণ তারিখগুলি থাকতে পারে এবং আপনাকে হয়ত নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। আপনার ভাষায় বিনামূল্যে এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদের তাদের সদস্য পরিচয়পত্রের পিছনে দেওয়া ফোন নম্বরে কল করা উচিত। অন্যরা 855-258-6518 নম্বরে কল করতে পারেন এবং 0 চাপ দেওয়ার জন্য অনুরোধ না করা পর্যন্ত সংলাপের জন্য অপেক্ষা করতে পারেন। যখন একজন এজেন্ট উত্তর দেবেন, তখন আপনার প্রয়োজনীয় ভাষাটি বলুন এবং আপনাকে একজন দোভাষীর সাথে সংযুক্ত করা হবে।

注意 (Chinese) : 此通知包含有關您的保險範圍的資訊。它可能包含關鍵日期，您可能需要在特定截止日期之前採取行動。您有權免費以您的語言獲取此資訊和協助。會員應撥打會員證背面的電話號碼。其他所有人可以撥打 855-258-6518 並等待對話框，直到提示按 0。當代理商接聽時，請說明您需要的語言，然後您將會與翻譯人員聯繫。

توجه (Farsi): این اطلاعیه حاوی اطلاعاتی درباره پوشش بیمه‌ای شما است. ممکن است شامل تاریخ‌های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به صورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می‌توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا دستور داده شود که عدد 0 را فشار دهند. هنگامی که یک نماینده پاسخ داد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

Attention (French): Le présent avis contient des informations essentielles relatives à votre couverture d'assurance. Il peut inclure des échéances importantes nécessitant une action de votre part dans un délai déterminé. Vous avez le droit d'obtenir ces informations ainsi qu'une assistance dans votre langue, et ce, sans frais. Les assurés sont invités à contacter le numéro figurant au verso de leur carte d'adhérent. Toute autre personne peut appeler le 855-258-6518 et patienter jusqu'à l'invitation à composer le 0. Lorsque votre appel sera pris en charge, indiquez la langue souhaitée afin d'être mis en relation avec un interprète.

Achtung (German): Dieser Hinweis enthält Informationen zu Ihrem Versicherungsschutz. Darin sind möglicherweise wichtige Termine aufgeführt und Sie müssen möglicherweise bis zu bestimmten Fristen Maßnahmen ergreifen. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Mitglieder sollten die Telefonnummer auf der Rückseite ihres Mitgliedsausweises anrufen. Alle anderen können 855-258-6518 anrufen und den Dialog abwarten, bis sie aufgefordert werden, die 0 zu drücken. Wenn ein Agent antwortet, geben Sie die gewünschte Sprache an und Sie werden mit einem Dolmetscher verbunden.

ध्यान दें (Hindi): इस नोटिस में आपके बीमा कवरेज के बारे में जानकारी है। इसमें महत्वपूर्ण तिथियां हो सकती हैं और आपको निश्चित समय सीमा तक कार्रवाई करनी पड़ सकती है। आपको यह जानकारी और सहायता अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सदस्यों को अपने सदस्य पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और 0 दबाने का संकेत मिलने तक संवाद की प्रतीक्षा कर सकते हैं। जब कोई एजेंट उत्तर दे, तो वह भाषा बताएं जिसकी आपको आवश्यकता है और आपको दुभाषिया से जोड़ा जाएगा।

Leruoanya (Igbo): ọkwà a nwere ozi bànyéré mkpuchi megide ihe mberede gị. Ọ nwere ike inwe ụbọchị ndị dị óké mkpà ma o nwekwara ike idị mkpa ka imee ihe tupu oge ụfọdụ agafee. Inwere ikike inweta ozi a ya na enyemaka na asụsụ gị n'akwughị ụgwọ ọbụla. Ndi ọtù ga akpọ ọnụọgụgụ ekwenti dị na àzụ Kààdị njirimara ndi ọtù ha. Ndi ọzọ nile nwere ike ikpọ 855-258-6518 ma chere geruo mkparịta ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara, kwuo asụsụ ichorọ, a ga ejikota gị na onye ntughari asụsụ.

Attenzione (Italian): Questa informativa contiene informazioni sulla copertura assicurativa. Potrebbe contenere date importanti e potrebbe essere necessario intraprendere azioni entro determinate scadenze. È possibile ottenere queste informazioni e assistenza nella propria lingua gratuitamente. I membri sono pregati di chiamare il numero di telefono riportato sul retro del proprio tesserino di riconoscimento. Tutti gli altri possono chiamare il numero 855-258-6518 e rimanere in linea fino a quando non viene richiesto di premere 0. Quando un operatore risponde, è necessario indicare la lingua desiderata per essere messi in contatto con un interprete.

주의 (Korean): 이 고지에는 귀하의 보험 적용 범위에 대한 정보가 포함되어 있습니다. 여기에는 주요 날짜가 포함되어 있을 수 있으며, 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하의 비용 없이 귀하의 언어로 이러한 정보와 지원을 받을 권리가 있습니다. 회원은 회원증 뒷면에 있는 전화번호로 전화하시기 바랍니다. 회원이 아닌 모든 분들은 855-258-6518 로 전화하여 안내 메시지가 끝날 때까지 기다렸다가 0 을 눌러주세요. 상담원이 통화에 응답했을 때, 필요한 언어를 말씀하시면 통역사와 연결됩니다.

Baa'ákonínízin (Navajo): Díí bee íł hane'í béeso nich'ááh naa'nil bee ník'é'ásti'í bódahólníihgo bee baa dahane'í biyi'. Dayoolkáí dóo bee ida'ii'aahí háidíí shíí t'áá bich'í'jì' ha'át'ííshíí ádadiilííhígíí biyi'. Díí bee baa dahane'í dóo t'áá jik'eh nizaad bee nika'e'eyeedgo bee ná'ahoot'í'. Bìł hada'dít'éhí binaaltsoos nitl'izhí bee béédahóziní bąąh béesh bee hane'í námboo biká'ígíí yee dahalne' dooleet. Nááná lá' íęęąęięęáí yee dahalne' dóo yáłti'í biba' asdáago niléí ó bíł adílchííd hodoo'niidjì'. Naalnishí haadzí'go, saad nínízinígíí bee bíł hodílnih dóo ata' yáłti'í bich'í' ni'doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरू हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरूले आफ्नो सदस्य परिचयपत्रको पछाडि रहेको फोन नम्बरमा कल गर्नुपर्छ। अरु सबैले 855-258-6518 मा कल गर्न सक्छन् र ० पुश गर्न प्रेरित नभएसम्म संवादको प्रतीक्षा गर्न सक्छन्। एजेन्टले जवाफ दिँदा, तपाईंलाई चाहिने भाषा बताउनुहोस् र तपाईंलाई दोभाषेसँग जोडिने छ।

Atenção (Portuguese): Este aviso contém informações sobre a cobertura do seu seguro. Ele pode conter datas importantes e você pode precisar tomar medidas dentro de determinados prazos. Você tem o direito de obter essas informações e assistência em seu idioma, sem nenhum custo. Os associados deverão ligar para o número de telefone indicado no verso do seu cartão de identificação de associado. Todos os outros podem ligar para 855-258-6518 e aguardar a mensagem até que seja solicitado a pressionar 0. Quando um agente atender, indique o idioma que você precisa e você será conectado a um intérprete.

Внимание (Russian): В настоящем уведомлении содержится информация о вашем страховом покрытии. Оно может содержать ключевые даты, и вам может потребоваться предпринять действия к определенным срокам. Вы имеете право получить эту информацию и помощь на своем языке бесплатно. Членам профсоюза следует звонить по номеру телефону, указанному на обратной стороне их удостоверения личности. Все остальные могут звонить по номеру 855-258-6518 и дожидаться диалога, пока не появится предложение нажать 0. Когда агент ответит, назовите нужный вам язык, и вас соединят с переводчиком.

Fa'alogo (Samoan): O lenei fa'aaliga o lo'o iai fa'amatalaga i vaega e kava e lau inisiua. E ono aofia ai aso taua ma atonu e te mana'omia ai le faia o se gaioiga i nisi taimi fa'agata. E iai lau aia tataua e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se totogi. E tataua i sui auai ona vili le numera o le telefoni i tua o le latou pepa faamaonia. O isi uma e mafai ona vala'au i le 855-258-6518 ma fa'atali i le talanoaga se'ia fa'atonuina e oomi le 0. A tali mai se so'o upu, fa'aailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'aliliu.

Pažnja (Serbian): Ovo obaveštenje sadrži informacije o vašem osiguranju. Može sadržati ključne datume i možda ćete morati da preduzmete akciju do određenih rokova. Imate prava da dobijete ove informacije i pomoć na vašem jeziku besplatno. Trebalo bi da članovi nazovu telefonski broj na poledini svoje članske legitimacije. Svi ostali mogu pozvati 855-258-6518 i sačekati automat dok ne dobiju obaveštenje da pritisnu taster "0". Kada se agent javi, navedite jezik koji vam je potreban i bićete povezani s prevodiocem

Atención (Spanish): Este aviso contiene información sobre su cobertura de seguro. Puede contener fechas clave y es posible que deba tomar medidas antes de determinadas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin coste alguno. Los afiliados deben llamar al número de teléfono que figura en el reverso de su tarjeta de identificación del afiliado. Todos los demás pueden llamar al 855-258-6518 y esperar el diálogo hasta que se les solicite presionar 0. Cuando un agente responda, indique el idioma que necesita y se conectará con un intérprete.

Atensyon (Tagalog): Ang abisong ito ay naglalaman ng impormasyon tungkol sa saklaw ng iyong insurance. Maaaring naglalaman ito ng mga mahahalagang petsa at maaaring kailanganin mong kumilos ayon sa ilang partikular na mga deadline. May karapatan kang makuha ang impormasyong ito at tulong sa iyong wika nang walang bayad. Ang mga miyembro ay dapat tumawag sa numero ng telepono sa likod ng kanilang member identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa masabihan na pindutin ang 0. Kapag sumagot ang isang ahente, sabihin ang wikang kailangan mo at ikaw ay ikokonek sa isang tagapagsalin.

توجہ (Urdu): اس نوٹس میں آپ کی انشورنس کوریج کے بارے میں معلومات شامل ہیں۔ اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے۔ آپ کو یہ معلومات اور مدد اپنی زبان میں، بغیر کسی قیمت کے حاصل کرنے کا حق ہے۔ ممبران کو اپنے رکنیتی کارڈ کی پشت پر دئے گئے فون نمبر پر کال کرنی چاہیے۔ باقی تمام لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبائے کا اشارہ ملنے تک ڈائلاگ پر انتظار کرنا چاہیے۔ جب کوئی ایجنٹ جواب دیتا ہے تو اپنی مطلوبہ زبان بتائیں اور آپ کا رابطہ ایک مترجم سے کر دیا جائے گا۔

Lưu ý (Vietnamese): Thông báo này có chứa thông tin về phạm vi bảo hiểm của bạn. Nó có thể chứa các ngày quan trọng và bạn có thể cần phải hành động theo thời hạn nhất định. Bạn có quyền nhận thông tin và hỗ trợ này bằng ngôn ngữ của mình mà không mất phí. Các thành viên nên gọi đến số điện thoại ở mặt sau thẻ thành viên của mình. Những người khác có thể gọi đến số 855-258-6518 và chờ qua hội thoại cho đến khi được nhắc nhấn số 0. Khi có nhân viên trả lời, hãy nêu ngôn ngữ bạn cần và bạn sẽ được kết nối với phiên dịch viên.