



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or sample plan document at <https://content.carefirst.com/sbc/contracts/2017.PerdueFarmsNimanRanch.pdf> or by logging into My Account.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In Network: <b>\$600</b> Individual, <b>\$1,200</b> Family. Out of Network: <b>\$1,200</b> Individual, <b>\$2,400</b> Family. <b><u>Deductible</u></b> does not apply to some services, including all In-Network Preventive care.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	There are no other specific <b><u>deductibles</u></b> .	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	In Network: <b>\$1,800</b> Individual, <b>\$3,600</b> Family. Out of Network: <b>\$3,600</b> Individual; <b>\$7,200</b> Family. Prescription drug benefits have separate limits: <b>\$4,800</b> Individual; <b>\$9,600</b> Family.	The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. See <a href="http://www.carefirst.com/naturalfoods">www.carefirst.com/naturalfoods</a> or call 1-844-405-2160 for a list of In-Network providers.	If you use an in-network doctor or other health care <b><u>provider</u></b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or In-Network for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 3 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b><u>excluded services</u></b> .

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



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

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copay	Deductible, then 40% of Allowed Benefit	-----None-----
	Specialist visit	\$30 copay	Deductible then, 40% of Allowed Benefit	-----None-----
	Other practitioner office visit	Chiropractic: Deductible, then 20% of Allowed Benefit	Chiropractic: Deductible, then 40% of Allowed Benefit	Chiropractic: Limited to 12 visits per coverage period.
	Retail Health Clinic	\$30 copay	Deductible, then 40% of Allowed Benefit	-----None-----
	Preventive care/ screening/immunization	No charge	Deductible then 40% of Allowed Benefit	Out-of-network services may have limitations or exclusions. Please see your contract.
If you have a test	Diagnostic test (x-ray, blood work)	Non-Hospital: No charge Hospital: 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
	Imaging (CT/PET scans, MRIs)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	Retail: \$10 copay. Mail Order: \$20 copay.	Retail: \$10 copay. Mail Order: \$20 copay.	Drugs listed on the formulary are covered. Drugs not listed on the formulary are not covered.  Generic and Brand drugs: Limited to 31-day supply (retail, non-specialty) or 93-day supply (mail order). Specialty drugs: Limited to 30-day supply.  Erectile dysfunction drugs are not covered.
	Brand drugs	Retail: \$30 copay. Mail Order: \$60 copay.	Retail: \$30 copay. Mail Order: \$60 copay.	
	Specialty drugs	Generic Specialty: \$10 copay. Brand Specialty: \$30 copay.	Generic Specialty: \$10 copay. Brand Specialty: \$30 copay.	
	Insulin, syringes, and diabetic supplies.	\$10 copay	\$10 copay	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
	Physician/surgeon fees	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
<b>If you need immediate medical attention</b>	Emergency room services	Deductible, then 20% of Allowed Benefit	Paid As In Network	-----None-----
	Emergency medical transportation	Deductible, then 20% of Allowed Benefit	Deductible, then 20% of Allowed Benefit	Prior authorization is required for air ambulance services, except for Medically Necessary air ambulance services in an emergency. Without prior authorization, you pay your deductible, then 50% coinsurance.
	Urgent care	\$30 copay	Deductible, then 40% of Allowed Benefit	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% coinsurance up to \$1000 per admission.
	Physician/surgeon fee	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Office Visit: No charge Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
	Mental/Behavioral health inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% coinsurance up to \$1,000 per admission.
	Substance use disorder outpatient services	Office Visit: No charge Facility: Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
	Substance use disorder inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% coinsurance up to \$1,000 per admission.
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Deductible, then 40% of Allowed Benefit	“No charge” applies to routine pre/postnatal office visits only.
	Delivery and all inpatient services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
<b>If you need help recovering or have other special health needs</b>	Home health care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 visits per coverage period. Prior authorization is required. Without prior authorization, you pay the deductible, then 50% coinsurance.
	Rehabilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 30 visits per coverage period for Speech Therapy, 60 visits per coverage period for Physical and Occupational Therapies combined, and 90 visits per coverage period for Cardiac Rehab.
	Habilitation services	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Same limits as Rehabilitation Services.
	Skilled nursing care	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Limited to 100 days per coverage period for a skilled nursing facility, 30 days per coverage period for outpatient private-duty nursing care.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Durable medical equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	-----None-----
	Hospice service	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit	Prior authorization is required. Without prior authorization, you pay the deductible, then 50% coinsurance. Limited to 185 days per lifetime for hospice care, 15 days per lifetime for inpatient hospice respite care, 15 days per lifetime for outpatient hospice respite care. Respite care must be used in increments of no more than 5 days at a time.
If your child needs dental or eye care	Eye exam	\$30 copay	Deductible, then 40% of Allowed Benefit	Limited to one exam per coverage period.
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Hearing Aids</li> <li>Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Chiropractic care (limited to 12 visits per coverage period)</li> <li>Most coverage provided outside the United States. See <a href="http://www.carefirst.com">www.carefirst.com</a></li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing (limited to 30 days per coverage period)</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Routine eye care (Adult) (limited to one exam per coverage period)</li> </ul>

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## Your Rights to Continue Coverage:

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

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

## Your Grievance and Appeals Rights:

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

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

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

## Does this Coverage Provide Minimum Essential Coverage?

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

## Does this Coverage Meet the Minimum Value Standard?

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

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

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## About these Coverage Examples:

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



### This is not a cost estimator.

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

See the next page for important information about these examples.

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

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$5,530
- Patient pays: \$2,010

#### Sample care costs:

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

#### Patient pays:

Deductibles	\$1,200
Copays	\$0
Coinsurance	\$660
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,010</b>

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

- Amount owed to providers: \$5,400
- Plan pays: \$3,528
- Patient pays: \$1,872

#### Sample care costs:

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

#### Patient pays:

Deductibles	\$1,200
Copays	\$490
Coinsurance	\$132
Limits or exclusions	\$50
<b>Total</b>	<b>\$1,872</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

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

### What does a Coverage Example show?

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

### Does the Coverage Example predict my own care needs?

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

### Does the Coverage Example predict my future expenses?

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

### Can I use Coverage Examples to compare plans?

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

### Are there other costs I should consider when comparing plans?

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

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## 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.

### Civil Rights Coordinator, Corporate Office of Civil Rights

Telephone Number 410-528-7820  
Mailing Address P.O. Box 8894  
Baltimore, Maryland 21224  
Fax Number 410-505-2011  
Email Address [civilrightscoordinator@carefirst.com](mailto:civilrightscoordinator@carefirst.com)

You can file a grievance by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

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>.

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## Foreign Language Assistance

*English (English):* Attention: 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.

*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 ከፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 1-855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

*Èdè Yorùbá (Yoruba)* Ìtètíléko: Àkíyèsí yìí ní ìwífún nípa isẹ̀ adójútòfò rẹ̀. Ó le ní àwọn déèti pàtó o sì le ní láti gbé igbésẹ̀ ní àwọn ojó gbèdèke kan. O ni ètò láti gba ìwífún yìí àti irànlowò ní èdè rẹ̀ lófèfẹ̀. Àwọn ọmọ-ẹgbé gbòdò pe nóm̩bà fòònù tò wà lẹ́yin káàdì idánimò wọn. Àwọn mírán le pe 1-855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tíítí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ 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 1-855-258-6518 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 1-855-258-6518 at maghintay hanggang sa dulo ng diyalogong 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 1-855-258-6518 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 1-855-258-6518 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 1-855-258-6518 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।

*Bàsɔ̀-wùdù (Bassa)* Tò Dùũ Cáo! Bǝ nìà kɛ bá nyo bǝ kɛ m̃ gbo kpá bó nì fùà-fúá-tiĩn nyɛɛ jè dyí. Bǝ nìà kɛ bédé wé jéé bǝ bɛ m̃ kɛ dɛ wa mɔ m̃ kɛ nyuɛɛ nyu hwɛ bɛ wé bɛa kɛ zi. ɔ mɔ nì kpé bɛ m̃ kɛ bǝ nìà kɛ kɛ gbo-kpá-kpá m̃ mɔɛɛ dyé dé nì bídí-wùdù mú bɛ m̃ kɛ se wídí dò pɛɛ. Kpooɔ nyo bǝ mɛ dá fúùn-nòbà nìà dé waa I.D. káàò dɛín nyɛ. Nyo tòò séín mɛ dá nòbà nìà kɛ: 1-855-258-6518, kɛ m̃ mɛ fò tee bɛ wa kée m̃ gbo cɛ bɛ m̃ kɛ nòbà mɔà 0 kɛɛ dyi pàdàìn hwɛ. ɔ jũ kɛ nyo dò dyi m̃ gǝ jũĩn, po wuɖu m̃ mɔ poɛ dyiɛ, kɛ nyo dò mu bó nìin bɛ ɔ kɛ nì wuɖu 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 1-855-258-6518 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 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 1-855-258-6518 پر کال کر سکتے ہیں اور 0 دہانے 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 1-855-258-6518 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 للأخريين الاتصال على الرقم 1-855-258-6518 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：本聲明可能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 1-855-258-6518，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 akwughị ugwo o bula. Ndi otu kwesiri ikpo akara ekwentị di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 1-855-258-6518 wee chere ubuho ahụ ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

*Deutsch (German)* Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 1-855-258-6518 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 +1 855 258 6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

*한국어 (Korean)* 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 1-855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.