The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact CareFirst at 1-800-296-0724. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.carefirst.com or call 1-800-296-0724 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com/fcps.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $250 Individual / $500 Family Out-of-Network: $500 Individual / $1,000 Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See https://www.healthcare.gov/coverage/preventive-care-benefits/ for a list of covered preventive services. See https://provider.carefirst.com/providers/medical/medical-policy.page? for colorectal cancer screening recommendations.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network and Out-of-Network (Combined) Out of Pocket Maximums: Medical: $2,000 Individual / $4,000 Family Pharmacy: $1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. For Pharmacy plan details, see http://info.caremark.com/fcps.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services. Copays and coinsurance for covered prescriptions apply to pharmacy out-of-pocket maximum.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Separate out-of-pocket maximums apply to medical and pharmacy benefits.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 800-296-0724 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	40% of Allowed Benefit	No visit limits.
	Specialist visit	$40 copay per visit	40% of Allowed Benefit	Certain therapeutic services limited to a 90-visit maximum, per therapy, per calendar year.
	Retail health clinic / Convenience care	$20 copay per visit, not subject to deductible.	40% of Allowed Benefit	None
	Preventive care/screening/ immunization	No charge, not subject to deductible.	40% of Allowed Benefit	Age & frequency limits may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% of Allowed Benefit	BlueChoice providers and outpatient facilities must use LabCorp for lab services to be covered in-network. If a BlueChoice provider refers you to a lab, you must use a LabCorp facility for lab services to be covered in-network.
	Imaging (CT/PET scans, MRIs)	Office (Non-Hospital) $75 copay per visit OP Facility (Hospital) $100 copay per visit	40% of Allowed Benefit	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://info.caremark.com/fcps .	Generic drugs	Retail: $7 / $14 / $21 (30 / 60 / 90-day supply) Mail Order: $14 (up to 90-day supply)	Pay in full, then file claim for reimbursement. Reimbursement limited to amount plan would have paid if network pharmacy was used.	Maximum $50 copay per 30-day supply of insulin. Participants using a CVS retail pharmacy for maintenance medications may receive a 90-day supply for two retail copays. Active Employees and Non-Medicare Retirees: Your plan uses a network of participating pharmacies and a formulary (a list of preferred covered medications). Some drugs may require preauthorization; if preauthorization is not obtained, the drug may not be covered. Deductible does not apply to prescription coverage. Certain preventive medications covered for $0 copay.
	Preferred brand drugs	20% subject to following maximums: Retail: $75 / $150 / $225 (30 / 60 / 90-day supply) Mail Order: $150 (up to 90-day supply)		
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% of cost of drug, $75 maximum, up to a 30-day supply	Must use CVS Specialty Pharmacy after first fill.	

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per visit	40% of Allowed Benefit	Prior authorization may be required depending on type of service rendered.
	Physician / surgeon fees	$20 PCP copay per visit $40 Spec copay per visit	40% of Allowed Benefit	
If you need immediate medical attention	Emergency room care	$250 copay then 10% of Allowed Benefit	Paid as In-Network if bona fide emergency	$250 copay waived if admitted. No coverage for non-emergency use; prudent layperson rules & definitions apply.
	Emergency medical transportation	10% of Allowed Benefit	10% of Allowed Benefit	Must be medically necessary.
	Urgent care	$40 copay per visit, not subject to deductible.	$40 copay per visit, not subject to deductible.	If using a non-participating provider, may be required to pay in full & file for reimbursement.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 admission copay, plus $100 copay per day (max 5 copays per admission)	$150 per admission copay then 40% of Allowed Benefit	Prior authorization is required for all inpatient admissions.
	Physician/surgeon fees	$20 PCP / $40 Spec copay per provider, per day	40% of Allowed Benefit	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit (office), $40 copay per visit (specialist), $100 copay facility charge (if applicable)	40% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, facility charge may apply. Prior authorization is not required for Outpatient Therapy Visits.
	Inpatient services	$150 admission copay, plus $100 copay per day (max 5 copays per admission)	40% of Allowed Benefit	Prior authorization is required for all inpatient hospital and treatment facility stays. Additional professional charges may apply
If you are pregnant	Office visits	No Charge	40% of Allowed Benefit	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization required for maternity & newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section.
	Childbirth/delivery professional services	$20 PCP / $40 Spec copay per provider, per day	40% of Allowed Benefit	
	Childbirth/delivery facility services	$150 admission copay, plus $100 copay per day (max 5 copays per admission)	$150 per admission copay then 40% of Allowed Benefit	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

If you need help recovering or have other special health needs	Home health care	$40 copay per visit	40% of Allowed Benefit	90 visits/calendar year; prior authorization is required
	Rehabilitation services	$40 copay per visit/therapy	40% of Allowed Benefit	Inpatient rehabilitation: 90 days per benefit period combined between in-network and out-of-network. Prior authorization required. Per admission copay may apply. Outpatient rehabilitation: In-network and out-of-network PT, OT, and ST benefits are limited to a 90-visit maximum combined per condition per calendar year and combined between in- and out-of-network. Utilization Management approval required. If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Habilitation services	$40 copay per visit/therapy	40% of Allowed Benefit	Prior authorization is required. Includes coverage for Autism Spectrum Disorder. Other habilitative services covered as part of Early Intervention Program (birth to age 3). If a service is rendered at a Hospital Facility, the additional Facility charge may apply.
	Skilled nursing care	Hospital Facility: $150 admission copay, plus $100 copay per day (max 5 copays per admission)	40% of Allowed Benefit	Prior authorization is required. 120-day maximum per benefit period; days renewed when out of the facility 60 consecutive days. $150 copay admission copay waived if transferred directly from inpatient facility.
	Durable medical equipment	$40 copay	40% of Allowed Benefit	Prior authorization is required for certain durable medical equipment. Please see the CareFirst Plan Booklet for more information.
	Hospice services	Outpatient: $40 copay per visit Hospital Facility: $150 admission copay, plus $100 copay per day (max 5 copays per admission)	$150 per admission copay then 40% of Allowed Benefit	Prior authorization is required. Inpatient per admission copay waived if transferred directly from inpatient or skilled nursing facility.
If your child needs dental or eye care	Children's eye exam	$20 copay, not subject to deductible	Reimbursement up to $40	Once every 12 months. Routine vision services not subject to deductible.
	Children's glasses	Standard glasses covered in full up to $130 allowance	Reimbursement $40 - $80	Lenses once per 12 months; frames once per 24 months; max $130 allowance
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult and child)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture – only if used by a physician in lieu of anesthesia
- Bariatric surgery - subject to Utilization Management approval
- Chiropractic care
- Infertility treatment – subject to Utilization Mgmt approval
- Hearing aids – only if result of accidental injury
- Non-emergency care when travelling outside the US. See www.bcbsglobalcore.com
- Private-duty nursing – outpatient only – limited to 120 days per benefit period
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at www.fcps.edu or 571-423-3200, Option 3. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.]

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist	$ 40
Hospital (facility) copay, then $100 per day copay (max 5 copays)	$150
Other	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$710**

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

The plan's overall deductible	$250
Specialist	$ 40
Hospital (facility) copay, then $100 per day copay (max 5 copays)	$150
Other	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,780**

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

The plan's overall deductible	$250
Specialist	$ 40
Hospital (facility) copay, then $100 per day copay (max 5 copays)	$150
Other	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (x-ray)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

Note: These numbers assume the patient does not participate in the plan's wellness incentive. If you participate in the plan's wellness incentive, you may be able to reduce your costs. For more information about the wellness incentive, please contact: www.carefirst.com/fcps.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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 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 ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን 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 ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ 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 nasasaklawan 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 सचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई हो सकता है कक इसमें मख्य ततथियों का उल्लेख हो और आपके ललए ककसी तनयत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और सबधि त सहायता अपनी भाषा में तनःशल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे हदए गए फोन नबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के ललए न कहा जाए, तब तक सवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर हदया जाएगा।

Bàsɔ́ɔ̀-wùqù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fù à-fűá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùqù mú ɓɛ́ m̀ ké se wíɖí qò pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ ɖá fűùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀mɛ fò tee ɓɛ́ wa kéɛ m̀gbo cɛ ɓɛ́ m̀ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwè. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা *(Bengali)* লক্ষ্য করুন: এই নন াটিশে আপনার ববমা কভ াশরজ সম্পশকে তথ্য রশেশে। এর মশযয গুরুত্বপূর্ে তাররখ থ্াকশত পাশর এবং বনবদে ষ্ট তাররশখর মশযয আপনাশক পদশক্ষপ বনশত হশত পাশর। ববনা খরশে বনশজর ভাষাতে এই তথ্য পাওেোর এবং সহাতেতা পাওেোর অবযকার আপনার আশে। সদসযশদরশক তাশদর পবরেেপশের বপেশন থ্াকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টিপশত না বলা পর্েন্ত অশপক্ষা করশত পাশরন। র্খন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলনু এবং আপনাশক নদাভাষীর সশে সাংর্ুক্ত করা হশব।

اردو (Urdu) نوٹس: یہ آپ کے انشورنس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں دی گئی 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 نمبر پر کال کرنی چاہیے۔ سیدھی 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 اعالمیه حاوی اطالعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و الزم است تا تاریخ. شما از این حق برخوردار هستید تا این اطالعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید.
اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان 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 انتخاب کنید تا به مترجم مربوطه وصل شوید.

العربية (Arabic) تنبيه: يحتوي هذا المخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد 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 خالل المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكالء، 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) 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 kwesịrị 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 아니신 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 ił hane'ígíí bii' dahólǫ́ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ́ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yáníłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.