



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 general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 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.

| 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 provider up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan , each family member may need to meet their own individual deductible , OR all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details. |
| Are there services covered before you meet your deductible ? | Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Outpatient Surgery, inpatient services, Emergency room, Urgent care, Mental health services office, Rehabilitation 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 a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. Prescription Drug: \$100 individual/ \$200 family. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | Medical: In-Network: \$1,500 individual/ \$3,000 family; Out-of-Network: \$3,000 individual/ \$6,000 family. Prescription Drug: In-Network: \$4,500 individual/ \$9,000 family. | The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan , each family member may need to meet their own out-of-pocket limits , OR all family members may combine to meet the overall family out-of-pocket limit , depending upon plan coverage. Please refer to your contract for further details. |

| | | |
|--|---|---|
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.carefirst.com or call 1-855-258-6518 for a list of provider network . | 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 I need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|--|--|---|---|
| | | In-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 | Provider: \$20 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Specialist visit | Provider: \$20 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Retail Health Clinic | \$20 copay per visit | Deductible, then 30% of Allowed Benefit | None |
| | Preventive care/screening/immunization | No Charge | Deductible, then 30% of Allowed Benefit | Some services may have limitations or exclusions based on your contract |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|--|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a test | Diagnostic test (x-ray, blood work) | LabTest: Non-Hospital: Deductible, then 10% of Allowed Benefit Hospital: Deductible, then 10% of Allowed Benefit XRay: Non-Hospital: Deductible, then 10% of Allowed Benefit Hospital: Deductible, then 10% of Allowed Benefit | LabTest: Non-Hospital: Deductible, then 30% of Allowed Benefit Hospital: Deductible, then 30% of Allowed Benefit XRay: Non-Hospital: Deductible, then 30% of Allowed Benefit Hospital: Deductible, then 30% of Allowed Benefit | None |
| | Imaging (CT/PET scans, MRIs) | Non-Hospital: Deductible, then 10% of Allowed Benefit Hospital: Deductible, then 10% of Allowed Benefit | Non-Hospital: Deductible, then 30% of Allowed Benefit Hospital: Deductible, then 30% of Allowed Benefit | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carefirst.com/rx | Generic drugs | Deductible, then \$10 copay | Paid As In-Network | For all prescription drugs: Prior authorization may be required for certain drugs; No Charge for preventive drugs or contraceptives; Copay applies to up to 34-day supply; Up to 90-day supply of maintenance drugs is 2 copays; |
| | Preferred brand drugs | Deductible, then \$30 copay | Paid As In-Network | |
| | Non-preferred brand drugs | Deductible, then \$55 copay | Paid As In-Network | |
| | Preferred Specialty drugs | Deductible, then 50% of Allowed Benefit up to \$75 | Not Covered | Specialty Drugs: Participating Providers: covered when purchased through the |
| | Non-preferred Specialty drugs | Deductible, then 50% of Allowed Benefit up to \$75 | Not Covered | Exclusive Specialty Pharmacy Network Non-Participating Providers: Not Covered |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|--|--|---|--|
| | | In-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) | Non-Hospital & Hospital: No Charge | Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit | None |
| | Physician/surgeon fees | Non-Hospital & Hospital: No Charge | Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit | None |
| If you need immediate medical attention | Emergency room care | \$100 copay per visit | Paid As In-Network | Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted |
| | Emergency medical transportation | Deductible, then 10% of Allowed Benefit | Paid As In-Network | Prior authorization is required for air ambulance services, except when Medically Necessary in an emergency |
| | Urgent care | \$20 copay per visit | \$20 copay per visit | Limited to unexpected, urgently required services |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Deductible, then 30% of Allowed Benefit | Prior authorization is required |
| | Physician/surgeon fee | No Charge | Deductible, then 30% of Allowed Benefit | None |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$20 copay per visit Hospital Facility: No Charge | Office Visit & Hospital Facility: Deductible, then 30% of Allowed Benefit | For treatment at an Outpatient Hospital Facility, additional charges may apply |
| | Inpatient services | No Charge | Deductible, then 30% of Allowed Benefit | Prior authorization is required; Additional professional charges may apply |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|--|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | No Charge | Deductible, then 30% of Allowed Benefit | For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply |
| | Childbirth/delivery professional services | No Charge | Deductible, then 30% of Allowed Benefit | None |
| | Childbirth/delivery facility services | No Charge | Deductible, then 30% of Allowed Benefit | Additional professional charges may apply |
| If you need help recovering or have other special health needs | Home health care | Deductible, then 10% of Allowed Benefit | Deductible, then 30% of Allowed Benefit | Prior authorization is required Benefits are limited to 90 days per benefit period. Renews when care not received for 60 consecutive days |
| | Rehabilitation services | Provider: \$20 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit | If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 30 visits combined per illness or injury per benefit period |
| | Habilitation services | Provider: \$20 copay per visit Hospital Facility: No Charge | Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit | Prior authorization is required after the first visit Benefits are limited to Members under the age of 21 If a service is rendered at a Hospital Facility, the additional Facility charge may apply |
| | Skilled nursing care | Deductible, then 10% of Allowed Benefit | Deductible, then 30% of Allowed Benefit | Prior authorization is required Benefits are limited to 60 days per benefit period |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Durable medical equipment | Deductible, then 10% of Allowed Benefit | Deductible, then 30% of Allowed Benefit | Prior authorization is required for specified services. Please see your contract |
| | Hospice services | Inpatient Care: Deductible, then 10% of Allowed Benefit Outpatient Care: Deductible, then 10% of Allowed Benefit | Inpatient Care: Deductible, then 30% of Allowed Benefit Outpatient Care: Deductible, then 30% of Allowed Benefit | Prior authorization is required; Hospice Maximum: Benefits are limited to 60 inpatient days per 180 day Hospice Eligibility Period Respite Care: Benefits are limited to 14 days Bereavement: Services must be rendered within 90 days following the death of a covered Member |
| If your child needs dental or eye care | Children's eye exam | \$10 copay per visit | Plan pays \$33, Member pays balance | Benefits are limited to 1 visit per benefit period |
| | Children's glasses | Discount program available to all Members | Not Covered | Benefits are limited to 1 set of glasses/lenses per benefit period |
| | Children's dental check-up | Not Covered | Not Covered | None |

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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> Infertility treatment Long-term care Private-duty nursing | <ul style="list-style-type: none"> 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.) | | |
|---|---|--|
| <ul style="list-style-type: none"> Abortion, except in limited circumstances Bariatric surgery Chiropractic care | <ul style="list-style-type: none"> Coverage provided outside the United States. See www.carefirst.com Hearing aids Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> 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. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://www.cciio.cms.gov>, or call 1-877-267-2323 x61565. 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 Labor Employee Benefits Security Administration, <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, <http://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, kwijigo 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 Copayment](#) \$20
- Hospital (facility) [Copayment](#) \$0
- Other [Coinsurance](#) 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 | \$0 |
| Coinsurance | \$125 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$10 |
|----------------------|------|

| | |
|-----------------------------------|--------------|
| The total Peg would pay is | \$385 |
|-----------------------------------|--------------|

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist Copayment](#) \$20
- Hospital (facility) [Copayment](#) \$0
- Other [Coinsurance](#) 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$250 |
| Copayments | \$600 |
| Coinsurance | \$76 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Joe would pay is | \$926 |
|-----------------------------------|--------------|

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist Copayment](#) \$20
- Hospital (facility) [Copayment](#) \$100
- Other [Coinsurance](#) 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|-------------|-------|
| Deductibles | \$250 |
| Copayments | \$230 |
| Coinsurance | \$105 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|--------------|
| The total Mia would pay is | \$585 |
|-----------------------------------|--------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 civilrightscordinator@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 yíí ní iwífún nípa isẹ̀ adójútòfò rẹ̀. Ó le ní àwọn déèti pátó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ojú gbèdẹ̀ke kan. O ni ètò láti gba iwífún yíí àti irànlówó ní èdè rẹ̀ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòò̀nù tó wà lẹ̀yìn káàdì idánimò wọn. Àwọn mírà̀n le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò 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.

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'i'ígíí bá. Bii' dahólóq doo íiyisíí yoolkaálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'i' díí bee íł hane' dóo níká'ádoowot 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'i' hodoonihjí'. Aadóo náána'la' éi kojí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį áádóo éi bikéé'dóo naasbaqas bił adidiilchit. Áká'anidaalwó'ígíí neidiitáágo, saad bee yáníłt'i'ígíí yii diikił dóo ata' halne'é lá níká'ádoowot.