

# BlueChoice Advantage Gold 1000 Ded Summary of Benefits

## Non-Integrated Deductible

| Services                                                                                                                                                                                                                                           | In-Network You Pay <sup>1</sup>                                                                                                                                                                                                   | Out-of-Network You Pay <sup>1</sup>            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Visit <a href="http://www.carefirst.com/doctor">www.carefirst.com/doctor</a> to locate providers and facilities                                                                                                                                    |                                                                                                                                                                                                                                   |                                                |
| 24-HOUR NURSE ADVICE LINE                                                                                                                                                                                                                          |                                                                                                                                                                                                                                   |                                                |
| Free advice from a registered nurse. Visit <a href="http://www.carefirst.com/needcare">www.carefirst.com/needcare</a> to learn more about your options for care.                                                                                   | When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options                                                                                           |                                                |
| WELLBEING PROGRAM & BLUE REWARDS                                                                                                                                                                                                                   |                                                                                                                                                                                                                                   |                                                |
| Visit <a href="http://www.carefirst.com/wellbeing">www.carefirst.com/wellbeing</a> for more information.                                                                                                                                           | You have access to a comprehensive wellbeing program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.                                 |                                                |
| ANNUAL MEDICAL DEDUCTIBLE (Benefit Period) <sup>2,3</sup>                                                                                                                                                                                          |                                                                                                                                                                                                                                   |                                                |
| Individual/Family                                                                                                                                                                                                                                  | \$1,000 Individual/\$2,000 Family (separate)                                                                                                                                                                                      | \$2,000 Individual/\$4,000 Family (separate)   |
| ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period) <sup>4,5</sup>                                                                                                                                                                                       |                                                                                                                                                                                                                                   |                                                |
| Individual/Family                                                                                                                                                                                                                                  | \$7,500 Individual/\$15,000 Family (separate)                                                                                                                                                                                     | \$15,000 Individual/\$30,000 Family (separate) |
| PREVENTIVE SERVICES                                                                                                                                                                                                                                |                                                                                                                                                                                                                                   |                                                |
| Well-Child Care (including exams & immunizations)                                                                                                                                                                                                  | No charge*                                                                                                                                                                                                                        | No charge*                                     |
| Adult Physical Examination (including routine GYN visit)                                                                                                                                                                                           | No charge*                                                                                                                                                                                                                        | No charge* after deductible                    |
| Breast Cancer Screening                                                                                                                                                                                                                            | No charge*                                                                                                                                                                                                                        | No charge*                                     |
| Pap Test                                                                                                                                                                                                                                           | No charge*                                                                                                                                                                                                                        | No charge*                                     |
| Prostate Cancer Screening                                                                                                                                                                                                                          | No charge*                                                                                                                                                                                                                        | No charge*                                     |
| Colorectal Cancer Screening                                                                                                                                                                                                                        | No charge*                                                                                                                                                                                                                        | No charge* after deductible                    |
| PCP AND SPECIALIST SERVICES                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |                                                |
| FACILITY CHARGE <sup>6</sup> —In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization) | Deductible, then \$50 per visit                                                                                                                                                                                                   | Deductible, then \$150 per visit               |
| Office Visits for Illness—PCP <sup>6,7</sup>                                                                                                                                                                                                       | Virtual Connect Plus through selected providers, including CloseKnit <sup>8</sup> - No charge* ( <a href="http://www.carefirst.com/virtualconnect">www.carefirst.com/virtualconnect</a> )<br>All other providers - \$15 per visit | Deductible, then \$50 per visit                |
| Office Visits for Illness—Specialist <sup>6,7</sup>                                                                                                                                                                                                | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |
| Allergy Testing <sup>6</sup>                                                                                                                                                                                                                       | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |
| Allergy Shots <sup>6</sup>                                                                                                                                                                                                                         | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |
| Physical, Speech, and Occupational Therapy <sup>6</sup>                                                                                                                                                                                            | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |
| Chiropractic <sup>6</sup>                                                                                                                                                                                                                          | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |
| Acupuncture <sup>6</sup>                                                                                                                                                                                                                           | \$40 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                |

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| Services                                                                                          | In-Network You Pay <sup>1</sup>                       | Out-of-Network You Pay <sup>1</sup>                              |
|---------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
| <b>IMMEDIATE AND EMERGENCY SERVICES</b>                                                           |                                                       |                                                                  |
| Convenience Care (retail health clinics such as CVS MinuteClinic)                                 | \$15 per visit                                        | Deductible, then \$50 per visit                                  |
| Urgent Care Center (such as Patient First or ExpressCare) <sup>9</sup>                            | \$50 per visit                                        | Deductible, then \$150 per visit                                 |
| Hospital Emergency Room Services <sup>9</sup>                                                     |                                                       |                                                                  |
| ■ Facility                                                                                        | Deductible, then \$500 per visit (waived if admitted) | In-network deductible, then \$500 per visit (waived if admitted) |
| ■ Physician                                                                                       | Deductible, then \$40 per visit                       | In-network deductible, then \$40 per visit                       |
| Ambulance (if medically necessary) <sup>9</sup>                                                   | Deductible, then \$40 per service                     | In-network deductible, then \$40 per service                     |
| <b>DIAGNOSTIC SERVICES</b>                                                                        |                                                       |                                                                  |
| Labs <sup>10</sup>                                                                                |                                                       |                                                                  |
| ■ Non-Hospital/Freestanding Facility                                                              | \$15 per visit                                        | Deductible, then \$65 per visit                                  |
| ■ Hospital                                                                                        | Deductible, then \$30 per visit                       | Deductible, then \$110 per visit                                 |
| X-ray <sup>10</sup>                                                                               |                                                       |                                                                  |
| ■ Non-Hospital/Freestanding Facility                                                              | \$30 per visit                                        | Deductible, then \$80 per visit                                  |
| ■ Hospital                                                                                        | Deductible, then \$60 per visit                       | Deductible, then \$110 per visit                                 |
| Imaging <sup>10</sup>                                                                             |                                                       |                                                                  |
| ■ Non-Hospital/Freestanding Facility                                                              | \$200 per visit                                       | Deductible, then \$250 per visit                                 |
| ■ Hospital                                                                                        | Deductible, then \$400 per visit                      | Deductible, then \$450 per visit                                 |
| <b>SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)</b> |                                                       |                                                                  |
| Outpatient Surgery (Non-Hospital)                                                                 |                                                       |                                                                  |
| ■ Facility                                                                                        | \$200 per visit                                       | Deductible, then \$300 per visit                                 |
| ■ Physician                                                                                       | \$40 per visit                                        | Deductible, then \$50 per visit                                  |
| Outpatient Surgery (Hospital)                                                                     |                                                       |                                                                  |
| ■ Facility                                                                                        | Deductible, then \$300 per visit                      | Deductible, then \$400 per visit                                 |
| ■ Physician                                                                                       | Deductible, then \$40 per visit                       | Deductible, then \$50 per visit                                  |
| Inpatient Surgery and Hospital Services                                                           |                                                       |                                                                  |
| ■ Facility                                                                                        | Deductible, then \$400 per admission                  | Deductible, then \$500 per admission                             |
| ■ Physician                                                                                       | Deductible, then \$40 per visit                       | Deductible, then \$50 per visit                                  |
| <b>HOSPITAL ALTERNATIVES</b>                                                                      |                                                       |                                                                  |
| Home Health Care (limited to 90 visits per episode of care)                                       | No charge*                                            | Deductible, then \$50 per visit                                  |
| Hospice Inpatient (Inpatient—limited to 60 days per hospice eligibility period)                   | No charge*                                            | Deductible, then \$50 per admission                              |
| Hospice Outpatient (Outpatient—limited to 180 days hospice eligibility period)                    | No charge*                                            | Deductible, then \$50 per visit                                  |
| Skilled Nursing Facility (limited to 60 days/benefit period)                                      | Deductible, then \$400 per admission                  | Deductible, then \$500 per admission                             |

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| Services                                                                                                       | In-Network You Pay <sup>1</sup>                                                                                                                                                                                                   | Out-of-Network You Pay <sup>1</sup>                                               |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>MATERNITY</b>                                                                                               |                                                                                                                                                                                                                                   |                                                                                   |
| Preventive Prenatal and Postnatal Office Visits                                                                | No charge*                                                                                                                                                                                                                        | Deductible, then \$50 per visit                                                   |
| Delivery and Facility Services                                                                                 | Deductible, then \$400 per admission                                                                                                                                                                                              | Deductible, then \$500 per admission                                              |
| Artificial and Intrauterine Insemination <sup>11,12</sup>                                                      | Benefits are available to the same extent as benefits provided for other services                                                                                                                                                 | Benefits are available to the same extent as benefits provided for other services |
| In Vitro Fertilization Procedures <sup>11,12</sup>                                                             | Benefits are available to the same extent as benefits provided for other services                                                                                                                                                 | Benefits are available to the same extent as benefits provided for other services |
| <b>MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)</b> |                                                                                                                                                                                                                                   |                                                                                   |
| Office Visit                                                                                                   | Virtual Connect Plus through selected providers, including CloseKnit <sup>8</sup> - No charge* ( <a href="http://www.carefirst.com/virtualconnect">www.carefirst.com/virtualconnect</a> )<br>All other providers - \$15 per visit | Deductible, then \$50 per visit                                                   |
| <b>Outpatient Services</b>                                                                                     |                                                                                                                                                                                                                                   |                                                                                   |
| ■ Facility                                                                                                     | \$50 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                                                   |
| ■ Physician                                                                                                    | \$30 per visit                                                                                                                                                                                                                    | Deductible, then \$50 per visit                                                   |
| <b>Inpatient Services</b>                                                                                      |                                                                                                                                                                                                                                   |                                                                                   |
| ■ Facility                                                                                                     | Deductible, then \$400 per admission                                                                                                                                                                                              | Deductible, then \$500 per admission                                              |
| ■ Physician                                                                                                    | Deductible, then \$30 per visit                                                                                                                                                                                                   | Deductible, then \$50 per visit                                                   |
| <b>MEDICAL DEVICES AND SUPPLIES</b>                                                                            |                                                                                                                                                                                                                                   |                                                                                   |
| Durable Medical Equipment                                                                                      | Deductible, then 25% of Allowed Benefit                                                                                                                                                                                           | Deductible, then 45% of Allowed Benefit                                           |
| Hearing Aids for Adults                                                                                        | Not covered                                                                                                                                                                                                                       | Not covered                                                                       |
| <b>PRESCRIPTION DRUGS<sup>13</sup></b>                                                                         |                                                                                                                                                                                                                                   |                                                                                   |
| Formulary List                                                                                                 | Visit <a href="http://www.carefirst.com/acarx">www.carefirst.com/acarx</a> to locate Formulary List                                                                                                                               |                                                                                   |
| Annual Prescription Drug Deductible                                                                            | \$250 per person<br>(waived for generic drugs; preferred and non-preferred brand insulin)                                                                                                                                         |                                                                                   |
| Preventive Drugs                                                                                               | No charge*                                                                                                                                                                                                                        |                                                                                   |
| Diabetic Supplies                                                                                              | No charge*                                                                                                                                                                                                                        |                                                                                   |
| Oral Chemo Drugs                                                                                               | No charge*                                                                                                                                                                                                                        |                                                                                   |
| Opioid Reversal Agents                                                                                         | No charge*                                                                                                                                                                                                                        |                                                                                   |
| Generic Drugs                                                                                                  | 30-day supply: \$15<br>90-day supply: \$30 (maintenance drugs only)                                                                                                                                                               |                                                                                   |
| Preferred Brand Drugs <sup>14</sup> (Preferred Insulin \$0)                                                    | 30-day supply: Deductible, then \$45<br>90-day supply: Deductible, then \$90 (maintenance drugs only)                                                                                                                             |                                                                                   |
| Non-preferred Brand Drugs <sup>15</sup> (Non-preferred Insulin capped at \$30 for 30 days/\$60 for 90 days)    | 30-day supply: Deductible, then \$65<br>90-day supply: Deductible, then \$130 (maintenance drugs only)                                                                                                                            |                                                                                   |
| Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)                        | 30-day supply: Deductible, then 50% coinsurance up to \$100 maximum<br>90-day supply: Deductible, then 50% coinsurance up to \$200 maximum (maintenance drugs only)                                                               |                                                                                   |
| Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)                    | 30-day supply: Deductible, then 50% coinsurance up to \$150 maximum<br>90-day supply: Deductible, then 50% coinsurance up to \$300 maximum (maintenance drugs only)                                                               |                                                                                   |

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| Services                                                                                                                                                   | In-Network You Pay <sup>1</sup>         | Out-of-Network You Pay <sup>1</sup>     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|
| <b>PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)</b>                                                             |                                         |                                         |
| Routine Exam (limited to 1 visit/benefit period)                                                                                                           | No charge*                              | Total charge minus \$40 reimbursement   |
| Frames and Contact Lenses—Pediatric Collection Only                                                                                                        | No charge*                              | Reimbursements apply                    |
| Spectacle Lenses                                                                                                                                           | Reimbursements apply                    | Reimbursements apply                    |
| <b>PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)</b>                                                             |                                         |                                         |
| Annual Dental Deductible                                                                                                                                   | \$25                                    | \$50                                    |
| Class I Preventative & Diagnostic Services—Exams, cleanings, fluoride treatments, sealants, bitewing x-rays <sup>16</sup> , full mouth x-ray <sup>17</sup> | No charge*                              | 20% of Allowed Benefit                  |
| Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics                                                     | Deductible, then 20% of Allowed Benefit | Deductible, then 40% of Allowed Benefit |
| Class III Major Services—Surgical periodontics, endodontics, oral surgery                                                                                  | Deductible, then 20% of Allowed Benefit | Deductible, then 40% of Allowed Benefit |
| Class IV Major Services—Restorative Crowns, dentures, inlays and onlays                                                                                    | Deductible, then 50% of Allowed Benefit | Deductible, then 65% of Allowed Benefit |
| Class V Medically Necessary Orthodontic Services                                                                                                           | 50% of Allowed Benefit                  | 65% of Allowed Benefit                  |

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Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges \$100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept \$50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to \$50.

**This summary is for comparison purposes only and does not create rights not given through the benefit plan. Not all services and procedures are covered by your benefits contract. Some services may have limitations or exclusions. For more information about plan benefits, limitations, exclusions and conditions of coverage, or for a copy of the complete terms of coverage please contact your employer or CareFirst.**

\* No copayment or coinsurance.

1. When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2. In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3. For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
4. For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.
5. All drug costs are subject to the in-network out-of-pocket maximum.
6. If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7. "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service. Providers will use their professional judgment to determine if a telemedicine visit is appropriate or if an in-person visit is required.
8. CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in person and telehealth services to CareFirst members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.
9. If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
10. Members accessing laboratory tests, x-rays, and specialty imaging services inside the CareFirst Service Area (Maryland, D.C., Northern Virginia) must use a designated Contracting Provider and/or Contracting Facility which may include a non-hospital/freestanding facility for In-Network benefits. Services performed by any other provider while inside the CareFirst Service Area will be considered Out-of-Network. Members accessing laboratory tests, x-rays, and specialty imaging services outside the CareFirst Service Area may use any participating BlueCard PPO facility and receive In-Network benefits.
11. Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.
12. Infertility services will be paid the same as other medical services including Office Visits, Surgery, General Ancillary, Lab, and Radiology benefits.
13. Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
14. If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand moves to the Non-preferred Brand drug tier.
15. If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.
16. Class I Preventative & Diagnostic Services - Exams, cleanings, fluoride treatments, sealants, bitewing x-rays are limited to 2 per year per provider per location.
17. Class I Preventative & Diagnostic Services - Full mouth x-ray is limited to 1 per every 3 years per provider per location.

**Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.**



CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

# 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<br>Lexington, KY 40512                                                               |
| Email Address    | <b><a href="mailto:civilrightscordinator@carefirst.com">civilrightscordinator@carefirst.com</a></b> |
| 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>**.

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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 ይዟል። ቁልፍ ቀናችን 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 ዐን እንዲጮኑ 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 ০ 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 بصورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج‌شده 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 banyéré mkpuchi megide ihe mberede gi. Ọ nwere ike inwe ụbọchị ndi 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 ekwentị dị na àzụ Káàdị njirimara ndi ọtù ha. Ndi ọzọ nile nwere ike jkpọ 855-258-6518 ma chere geruo mkparịta ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara, kwuo asụsụ ichọrọ, a ga ejikota gi 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. 귀하는 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 íí hane'í béeso nich'ááh naa'nil bee ník'é'asti'í bódahólníhgo bee baa dahane'í biyi'. Dayoolkáí dóó bee ida'íi'aahí háidíí shíí t'áá bich'í'jì' ha'át'íishíí ádadíilííhígíí biyi'. Díí bee baa dahane'í dóó t'áá jiiik'eh nizaad bee níka'e'eyeedgo bee ná'ahoot'í'. Bìl hada'dít'éhí binaaltsoos nit'í'izhí bee béédahóziní baa'ah béesh bee hane'í námboo biká'ígíí yee dahalne' dooleeł. Nááná ła' 855-258-6518 yee dahalne' dóó yáfti'í biba' asdaago niléí ó bíl adíłchííł hodoo'niidjì'. Naalnishí haadzí'go, saad nínízinígíí bee bíl hodíilnih dóó ata' yáfti'í bich'í' nì' doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरु हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरुले 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 дождаться 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 inisia. 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 tatau e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se tofogi. E tatau 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'ailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'alilili.

**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 دیے 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.