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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $500 individual/ $1,000 family; Out-of-Network: $1,000 individual/ $2,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Primary care, Specialist, Retail health, Imaging, Prescription drugs, Emergency room, Urgent care, Mental Health office visit, Rehabilitation services.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Medical: In-Network: $1,500 individual/ $4,500 family; Out-of-Network: $3,000 individual/ $9,000 family. Prescription Drug: In-Network: $4,500 individual/ $9,000 family.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Provider: $40 copay per visit Hospital Facility: Deductible, then No Charge</td>
<td>Provider &amp; Hospital Facility: Deductible, then 30% of Allowed Benefit</td>
<td>If a service is rendered at a Hospital Facility, the additional Facility charge may apply</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>Provider: $40 copay per visit Hospital Facility: Deductible, then No Charge</td>
<td>Provider &amp; Hospital Facility: Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Retail Health Clinic</td>
<td>$40 copay per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
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<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Well Child Care &amp; All Related Services: 30% of Allowed Benefit Adult Physical, Routine GYN &amp; All Related Services: Deductible, then 30% of Allowed Benefit Breast Cancer Screenings, Pap Test, Prostate Cancer Screenings, Colorectal Screenings &amp; All Related Services: No Charge</td>
<td>Some services may have limitations or exclusions based on your contract</td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>LabTest: Non-Hospital: Deductible, then 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit XRay: Non-Hospital: Deductible, then 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit</td>
<td>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</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Hospital: 20% of Allowed Benefit Hospital: Deductible, then 20% of Allowed Benefit</td>
<td>Non-Hospital: Deductible, then $30 copay per visit Hospital: Deductible, then 30% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 copay</td>
<td>Paid As In-Network</td>
<td>For all prescription drugs: Prior authorization may be required for</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong>&lt;br&gt;More information about prescription drug coverage is available at <a href="http://www.carefirst.com/rx">www.carefirst.com/rx</a></td>
<td>Preferred brand drugs</td>
<td>$30 copay</td>
<td>Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50 copay</td>
<td>Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Preferred Specialty drugs</td>
<td>50% of Allowed Benefit up to a maximum of $100</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Specialty drugs</td>
<td>50% of Allowed Benefit up to a maximum of $150</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Non-Hospital &amp; Hospital: Deductible, then No Charge</td>
<td>Non-Hospital &amp; Hospital: Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Non-Hospital &amp; Hospital: Deductible, then No Charge</td>
<td>Non-Hospital &amp; Hospital: Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$200 copay per visit</td>
<td>Paid As In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Deductible, then No Charge</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$100 copay per visit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit: $40 copay per visit</td>
<td>Office Visit &amp; Hospital Facility: Deductible, then No Charge</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Provider &amp; Hospital Facility: $40 copay per visit</td>
<td>Provider &amp; Hospital Facility: Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Provider &amp; Hospital Facility: $40 copay per visit</td>
<td>Provider &amp; Hospital Facility: Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Deductible, then 30% of Allowed Benefit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
</tbody>
</table>
| Durable medical equipment | Deductible, then No Charge | Deductible, then 30% of Allowed Benefit | Prior authorization is required for specified services.
|                      |                       | Inpatient Care: Deductible, then 20% of Allowed Benefit | Outpatient Care: Deductible, then 20% of Allowed Benefit |
| Hospice services     |                       | Inpatient Care: Deductible, then 30% of Allowed Benefit | Prior authorization is required; Hospice Maximum: Benefits are limited to 180 lifetime days inpatient/outpatient combined 60 days inpatient per lifetime Respite Care: Benefits are limited to 14 days Bereavement: Must be rendered within 90 days following the death of a covered member Family Counseling: Applies to the 180 day Hospice Maximum |
|                      |                       | Outpatient Care: Deductible, then 30% of Allowed Benefit | |
| 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 Programs 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.):**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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SBC ID: SBC20191108MANNNS00590600000000N112019
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion, except in limited circumstances</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Coverage provided outside the United States.</td>
</tr>
<tr>
<td>See <a href="http://www.carefirst.com">www.carefirst.com</a></td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
</tbody>
</table>

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](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](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](http://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](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](http://www.cciio.cms.gov), or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

——— 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**: $500
- **Specialist Copayment**: $40
- **Hospital (facility) Coinsurance**: 20%
- **Other Coinsurance**: 20%

**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**: $12,800

**In this example, Peg would pay:**

- **Cost Sharing**
  - Deductibles: $500
  - Copayments: $0
  - Coinsurance: $1,714

**What isn't covered**
- Limits or exclusions: $10

The total Peg would pay is **$2,224**

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

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

- **The plan's overall deductible**: $500
- **Specialist Copayment**: $40
- **Hospital (facility) Coinsurance**: 20%
- **Other Coinsurance**: 20%

**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: $500
  - Copayments: $1,020
  - Coinsurance: $12

**What isn't covered**
- Limits or exclusions: $0

The total Joe would pay is **$1,532**

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

- **The plan's overall deductible**: $500
- **Specialist Copayment**: $40
- **Hospital (facility) Copayment**: $200
- **Other Coinsurance**: 20%

**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: $500
  - Copayments: $440
  - Coinsurance: $10

**What isn't covered**
- Limits or exclusions: $0

The total Mia would pay is **$950**

SBC ID: SBC20191108MANNS00590600000000N112019
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
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)

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.

 المتحدة (Arabic): هذه الرسالة تحتوي على معلومات عن مغطى您的保险覆盖。它可能包含关键日期和您需要在特定截止日期采取行动。您有权获取此信息和帮助您的语言，没有任何成本。成员应拨打其成员身份证背面的电话号码。所有其他人可以拨打855-258-6518并等待通过对话，直到被提示按0。当代理应答时，声明您需要的语言并您将被连接到一个翻译。

Edė Yoruba (Yoruba): Akiyewi yi ni iwifun nipa iṣe ọdùjù-ọfọ re. Ò le ni awon déètì pàtò o si le ni láti gbé ịgbēsị ní awon ọjọ gbédéde kan. O ni ètò láìti gba iwifun yií àti irànlàwò ni èdè re lófìrò. Àwọn ọmọ-egbè gbòdò pe nómìbà fóónu tó wà léyín kààdì idáànmì wọn. Àwọn miràn le pe 855-258-6518 kí o si dùró nípasè ijiırò títì a ó fí sò fun ọ láti tè 0. Nígbàti aṣọjú kan bá dàhùn, sọ èdè tì o fè a ó sì so ọ pò mò ọgbudò 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 nguyên tắc trong 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 mất sau của thể nhân dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đợi cho đến khi được nhắc nhắc nhặt 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 tổng đài viên.


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, indíquele el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian): Внимание! Наиболее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнение некоторых действий до определенного срока. Вы можете получать бесплатную информацию 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.
हिंदी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तथ्यों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निष्कर्ष पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिखाए गए फोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक दो दिनों के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएं और आपको व्याख्यायार के केन्द्रक कर दिया जाएगा।

Bàsì̀-wùdù (Bassa) Tô Đùu Cáło! Bô nià ke bá nyo bê kë m go bo kpá bô ni ùù-fàùù-tùùni nyee jè dyì. Bô nià ke bëdë wë jëè bë bë m ke dë wë m go wë bëa dë kë. J më ni kpë bë m ke bë nià ke go bo kpá-kpá m móë dyë dë ni bëi-wùdù mú bë m ke ùù wëdï dë péë. Kpòò nyo bë me dà ùù-môbô nià dë waà I.D. kàáà déen nyë. Nyo tô sëin me dà nôbô nià ke: 855-258-6518, kë m òo têe bë wa kë m go cê bë m ke nôbô móa 0 ke dyì pààdiùn wëwë. J jù kë nyë dë dyì m go jùùn, po wëdë m òo pëe dyë, kë nyë dö më bô nin bë cë ni wùdù mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশ আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে প্রকৃতপক্ষে তারিখ থাকতে পারে এবং নিষ্ঠার ভিত্তিতে আপনাকে পদক্ষেপ নিতে হবে পারে। বিমা লক্ষ্যের ভাষায় এই তথ্য পাওয়ার এবং ভাষাত পাওয়ার অধিকার আপনার আছে। সমস্তকরণ জন্য পরিচিতিপত্রে যে ভাষা ব্যবহার করতে হবে তার কেন্দ্রক। এখানে রয়েছে 855-258-6518 নম্বর করে 0 টিনপেট যা বড় সম্প্রসারণ করতে পারেন। যখন কোনো এজেন্ট উত্তর দেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে সহকারীর সাথে সম্পর্ক করতে হবে।

اردو (Urdu) نواحی، زیادہ بنیاد سے کھڑکی سے گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوڑھاٹ گھوড़ा (Farsi) کر ناکه چند لیکش تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا سطح تا स्थिति (Arabic) مُوْقَعُ مَعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّمَّعْلُومٍ مِّم*
Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. Ọ nwere ihe ụbọchị ndị mkpa, i nwere ihe ime ihe tupu ufodụ ụbọchị njedebe. I nwere iike nweta ozi na enyemaka a n’asusu gi na akwụghị ugwo ọ bula. Ndị otu kwesịị ike akara ekwenti di n’azu ne kaadị njirimara ha. Ndị ọzọ niile nwere ike ikepọ 855-258-6518 wee chere ụbọchị ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asusu i chọrọ, a ga-ekikọ gi na onye ọkọwa okwu.


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 souhaitiez 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 il hane’íígíi bií dahóló bee éédahózin béeso ách’áah naanil ník’ist’íígíi bá. Bií dahólójó doo iyisíí yoolkááílíigíi dóó t’aáado le’é ádadooyílíigíi da yókeedgo t’áá doo bee e’e’ahá ajjil’jíh. Bee ná ahóó’tí’ dií bee il hane’ dóó niká’ádoowol t’áá nínizaad bee t’áá jiik’é. Atah daníñiníií biésh bee hane’é bee wólta’íígíi nit’ízgo bee nee hódolzíiníií bikéédéé’ bikáá’ bich’í’ hodoonihíjí. Aadóó nánáñla’ éi kojí dahóóoolnih 855-258-6518 dóó yíi diíts’íjí yalt’ííígíi t’áá niléjíi ááádóó éi bikéé’dóó naasbaqs bit addidilkíití. Áká’ándaalwó’ííígíi neiidiitáágo, saad bee yánít’ííígíí yíi diíkií dóó ata’ halne’ lá niká’ádoowlolw.