Virginia Consumer Health Benefits 2023

CareFirst
Family of health care plans

Know before you go

Your health, your money, your decision

PCP visits: The lowest copays and the best option for consistent, quality care.

Caution: Services on a hospital campus may incur a separate hospital charge.

Retail health clinics: Low copays and after-hours care for minor health concerns.

Caution—Emergency room: Highest out-of-pocket costs; explore other options for non-emergency care.

Labs/X-rays/Imaging: Use non-hospital facilities for the lowest copays.

Caution: These services will cost more if performed in a hospital.

Surgeries: Non-hospital (ambulatory) surgery centers will save you money on many outpatient surgeries.

Generic drugs: Always your lowest cost option; some are no charge and no deductible.

Caution: For the lowest cost, always visit doctors who are in-network.

		Silver				Gold				Catastrophic
	Virginia CareFirst Plans	**BlueChoice HMO HSA Silver $3,000**	**BluePreferred PPO HSA Silver $3,000**	**BlueChoice HMO Standard Silver $5,800**	**BluePreferred PPO Standard Silver $5,800**	**BlueChoice HMO Gold $1,750**	**BluePreferred PPO Gold $1,750**	**BlueChoice HMO Standard Gold $2,000**	**BluePreferred PPO Standard Gold $2,000**	**BlueChoice HMO Young Adult $9,100**
	Plan Type	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]	PPO[2]	HMO[1]
	Visit **carefirst.com/doctor** to view participating doctors and facilities—search by plan:	**BlueChoice HMO**	**BluePreferred PPO**	BlueChoice HMO	BluePreferred PPO	**BlueChoice HMO**	**BluePreferred PPO**	**BlueChoice HMO**	**BluePreferred PPO**	**BlueChoice HMO**
	DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	In-Network	In-Network			In-Network	In-Network			In-Network
1	**Deductible**[3]	Individual: $3,000/Family: $6,000	Individual: $3,000/Family: $6,000	Individual: $5,800/Family: $11,600	Individual: $5,800/Family: $11,600	Individual: $1,750/Family: $3,500	Individual: $1,750/Family: $3,500	Individual: $2,000/Family: $4,000	Individual: $2,000/Family: $4,000	Individual: $9,100/Family: $18,200
2	**Out-of-Pocket Maximum**[4]	Individual: $6,500/Family: $13,000	Individual: $6,500/Family: $13,000	Individual: $8,900/Family: $17,800	Individual: $8,900/Family: $17,800	Individual: $6,650/Family: $13,300	Individual: $6,650/Family: $13,300	Individual: $8,700/Family: $17,400	Individual: $8,700/Family: $17,400	Individual: $9,100/Family: $18,200
	PREVENTIVE SERVICES									
3	**Preventive Care** (e.g. adult physical, well-child care, cancer screenings)	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	PRIMARY CARE AND SPECIALIST SERVICES									
4	**Primary Care Provider (PCP) Visits—Office/Non-Hospital** (non-preventive)	$30 copay after deductible	$30 copay after deductible	$40 copay, no deductible	$40 copay, no deductible	No charge, no deductible	No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
5	**Specialist Visits—Office/Non-Hospital**	$40 copay after deductible	$40 copay after deductible	$80 copay, no deductible	$80 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$60 copay, no deductible	$60 copay, no deductible	No charge after deductible
6	**HOSPITAL CHARGE** Add this charge if your primary care or specialist visit takes place in a hospital setting	$100 copay after deductible	$100 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$75 copay after deductible	$75 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	RETAIL CLINICS, URGENT AND EMERGENCY SERVICES									
7	**Convenience Care/Retail Health Clinics**	$30 copay after deductible	$30 copay after deductible	$40 copay, no deductible	$40 copay after deductible	No charge, no deductible	No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	No charge after deductible
8	**Urgent Care Center**	$60 copay after deductible	$60 copay after deductible	$60 copay, no deductible	$60 copay after deductible	$50 copay, no deductible	$50 copay, no deductible	$45 copay, no deductible	$45 copay, no deductible	No charge after deductible
9	**Emergency Room** (hospital charge—copays are waived if you are admitted)	$300 copay after deductible	$300 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$300 copay after deductible	$300 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
	DIAGNOSTIC SERVICES									
10	**Labs**[6] Office/Non-Hospital	$25 copay after deductible (LabCorp only)	$25 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$15 copay, no deductible (LabCorp only)	$15 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible (LabCorp only)
11	**Labs**[6] Outpatient Hospital	$90 copay after deductible[7]	$90 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$60 copay after deductible[7]	$60 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
12	**X-rays**[6] Office/Non-Hospital	$55 copay after deductible	$55 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$65 copay, no deductible	$65 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
13	**X-rays**[6] Outpatient Hospital	$130 copay after deductible[7]	$130 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$100 copay after deductible[7]	$100 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
14	**Imaging** (e.g. MRI, Cat Scan, CT Scan) Office/Non-Hospital	$250 copay after deductible	$250 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$250 copay, no deductible	$250 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
15	**Imaging** (e.g. MRI, Cat Scan, CT Scan) Outpatient Hospital	$500 copay after deductible[7]	$500 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$350 copay after deductible[7]	$350 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
	OUTPATIENT SURGERY *(Members are responsible for both facility and physician charges)*									
16	**Outpatient Surgery** (physician charge) Non-Hospital/Surgical Center	$40 copay after deductible	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$30 copay, no deductible	$30 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
17	**Outpatient Surgery** (physician charge) Hospital	$40 copay after deductible[7]	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$30 copay after deductible[7]	$30 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
18	**Outpatient Surgery** (facility charge) Non-Hospital/Surgical Center	$300 copay after deductible	$300 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$300 copay, no deductible	$300 copay, no deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
19	**Outpatient Surgery** (facility charge) Hospital	$450 copay after deductible[7]	$450 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$400 copay after deductible[7]	$400 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
	INPATIENT HOSPITAL SERVICES *including all inpatient surgery, labor & delivery, mental health related visits (Members are responsible for both hospital and physician charges)*									
20	**Inpatient Services** (physician charge)	$40 copay after deductible	$40 copay after deductible	40% coinsurance after deductible	40% coinsurance after deductible	$30 copay after deductible	$30 copay after deductible	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible
21	**Inpatient Services** (hospital charge)	$500 copay/day after deductible (up to a copay maximum of $2,500)[7]	$500 copay/day after deductible (up to a copay maximum of $2,500)	40% coinsurance after deductible	40% coinsurance after deductible	$450 copay/day after deductible (up to a copay maximum of $2,250)[7]	$450 copay/day after deductible (up to a copay maximum of $2,250)	25% coinsurance after deductible	25% coinsurance after deductible	No charge after deductible[7]
	MATERNITY OFFICE VISITS									
22	**Preventive Prenatal & Postnatal Office Visits**[8]	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible
	MENTAL HEALTH & SUBSTANCE ABUSE									
23	**Office Visits**	$30 copay after deductible	$30 copay after deductible	$40 copay, no deductible	$40 copay, no deductible	No charge, no deductible	No charge, no deductible	$30 copay, no deductible	$30 copay, no deductible	Visits 1–3: No charge, no deductible[5] Visits 4+: No charge after deductible
	PRESCRIPTION DRUGS[9]									
24	**Prescription Drug Deductible**	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	No separate drug deductible; Must meet medical deductible first	$150 per person (Tiers 2–5)	$150 per person (Tiers 2–5)	$0	$0	No separate drug deductible; Must meet medical deductible first
25	**Preventive Drugs (Tier 0)**	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge, no deductible	No charge	No charge	No charge, no deductible
26	**Diabetic Supplies (Tier 0)**									
27	**Preferred Brand Insulin (Tier 0)**									
28	**Generic Drugs (Tier 1)**	$10 copay after deductible	$10 copay after deductible	$20 copay, no deductible	$20 copay, no deductible	No charge, no deductible	No charge, no deductible	$15 copay	$15 copay	No charge after deductible
29	**Preferred Brand Drugs (Tier 2)**[10]	$50 copay after deductible	$50 copay after deductible	$40 copay, no deductible	$40 copay, no deductible	$50 copay after deductible	$50 copay after deductible	$30 copay	$30 copay	No charge after deductible
	Non-Preferred Brand Insulin (Tier 3)	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay, no deductible	$30 copay	$30 copay	No charge, no deductible
	Non-Preferred Brand Drugs (Tier 3)[11]	$70 copay after deductible	$70 copay after deductible	$80 copay after deductible	$80 copay after deductible	$70 copay after deductible	$70 copay after deductible	$60 copay	$60 copay	No charge after deductible
	Preferred Specialty Drugs (Tier 4)[12]	$100 copay after deductible	$100 copay after deductible	$350 copay after deductible	$350 copay after deductible	$100 copay after deductible	$100 copay after deductible	$250 copay	$250 copay	
	Non-Preferred Specialty Drugs (Tier 5)[12]	$150 copay after deductible	$150 copay after deductible	$350 copay after deductible	$350 copay after deductible	$150 copay after deductible	$150 copay after deductible	$250 copay	$250 copay	
	OUT-OF-NETWORK		Out-of-Network	Out-of-Network	Out-of-Network		Out-of-Network	Out-of-Network	Out-of-Network	
30	**Deductible**	N/A	Individual: $6,000/Family: $12,000	N/A	Individual: $11,600/Family: $23,200	N/A	Individual: $3,500/Family: $7,000	N/A	Individual: $4,000/Family: $8,000	N/A
31	**Out-of-Pocket Maximum**	N/A	Individual: $13,000/Family: $26,000	N/A	Individual: $17,800/Family: $35,600	N/A	Individual: $13,300/Family: $26,600	N/A	Individual: $17,400/Family: $34,800	N/A

Note: When multiple services are rendered on the same day by more than one provider, member payments are required for each provider.

[1] Health Maintenance Organization (HMO) plans underwritten by CareFirst BlueChoice, Inc.

[2] Preferred Provider Organization (PPO) plans underwritten by Group Hospitalization and Medical Services, Inc.

[3] For family coverage only—If one member on the policy meets the individual deductible, full benefits will begin for that member. That member will not be able to contribute more than the individual deductible amount towards the family deductible. Once the family deductible has been met, full benefits will be available to all members on the policy.

[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.

[5] You receive up to 3 non-preventive primary care visits without needing to meet a deductible.

[6] HMO plans: For in-network benefits, members must use LabCorp for laboratory services and freestanding facilities for diagnostic services and X-rays.

[7] Prior authorization required.

[8] For non-routine obstetrical care or complications of pregnancy, cost-sharing may apply.

[9] All out-of-pocket drug costs contribute to the in-network out-of-pocket maximum.

[10] If a generic drug becomes available for a preferred brand drug, the preferred brand drug moves to the non-preferred brand drug tier.

[11] 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 as stated above 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 in-network out-of-pocket maximum.

[12] Specialty drugs must be obtained through mail order at CVS Specialty Pharmacy.

To view participating pharmacies and find out how drugs are covered (e.g. generic vs. non-preferred brand) please visit **carefirst.com/acarx**. Please note there are coverage limitations for using non-participating pharmacies.

See a summary of any plan and a glossary of common health insurance terms by visiting **carefirst.com/individual**. Just enter your zip code, gender and date of birth to view and compare plans. Look for the Summary of Benefits & Coverage and Uniform Glossary of Coverage & Medical Terms links for each plan by clicking on the plan name and scrolling to the bottom of the box.

Questions? Ask your broker or call one of our product specialists at 410-356-8000 or toll-free at 800-544-8703 Monday–Friday, 8 a.m.–6 p.m. and Saturday, 8 a.m.–noon.

2023 Virginia Policy Form Numbers:

BlueChoice HMO HSA Silver $3,000
VA/CFBC/DB/HMO (1/23); VA/CFBC/EXC/HMO HSA/SIL 3000 (1/23); MVAAP (3.22)

BlueChoice HMO Standard Silver $5,800
VA/CFBC/DB/HMO (1/23); VA/CFBC/EXC/HMO STAND/SIL 5800 (1/23); MVAAP (3.22)

BlueChoice HMO Gold $1,750
VA/CFBC/DB/HMO (1/23); VA/CFBC/EXC/BC HMO/GOLD 1750 (1/23); MVAAP (3.22)

BlueChoice HMO Standard Gold $2,000
VA/CFBC/DB/HMO (1/23); VA/CFBC/EXC/HMO STAND/GOLD 2000 (1/23); MVAAP (3.22)

BlueChoice HMO Young Adult $9,100
VA/CFBC/DB/HMO (1/23); VA/CFBC/EXC/HMO/YA SOB (1/23); MVAAP (3.22)

BluePreferred PPO HSA Silver $3,000
VA/CF/DB/BP (1/23); VA/CF/EXC/BP PPO HSA/SIL 3000 (1/23); MVAAP (3.22)

BluePreferred PPO Standard Silver $5,800
VA/CF/DB/BP (1/23); VA/CF/EXC/BP PPO/STAND SIL 5800 (1/23); MVAAP (3.22)

BluePreferred PPO Gold $1,750
VA/CF/DB/BP (1/23); VA/CF/EXC/BP PPO/GOLD 1750 (1/23); MVAAP (3.22)

BluePreferred PPO Standard Gold $2,000
VA/CF/DB/BP (1/23); VA/CF/EXC/BP PPO/STAND GOLD 2000 (1/23); MVAAP (3.22)

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-258-6518
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-258-6518

Not all services and procedures are covered by your benefits contract.
This benefit summary is for comparison purposes only and does not create rights not given through the benefit plan.
The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued.
For costs and complete details of the coverage, call your insurance agent or CareFirst.

CareFirst
Family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., First Care, 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.

CDS1219-1P (9/22)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and 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.

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0. *When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ(Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Ɖùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fûà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwɛ̀ ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fǔùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàɖàìn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̌ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

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

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ́ bee éédahózin béeso ách'ą́ą́h naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ́ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyį́į́lígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'į́į́h. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédę́ę́' bikáá' bich'į' hodoonihjį́'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'į́ił yałtí'ígíí t'áá níléíjį́ áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ą́go, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.