This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [http://benefits.jhu.edu/health-and-life/medical-plans.cfm](http://benefits.jhu.edu/health-and-life/medical-plans.cfm) or by calling 410-516-2000.

<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>$500 Individual; $1,500 Family (Combined deductible for Johns Hopkins providers and all other providers)</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>There is a $150 per admission deductible.</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>$1,500 Individual; $4,500 Family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of preferred providers, see <a href="http://www.carefirst.com">www.carefirst.com</a> or call 1-855-258-6518.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, preferred, or participating for <strong>providers</strong> in their network. See the chart starting on page 3 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes</td>
<td>Some of the services this plan doesn’t cover are listed on page 8. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

Questions: If you are a member please call the number on your ID card or visit [www.carefirst.com](http://www.carefirst.com). Otherwise, please call 1-855-258-6518. If you aren’t clear about any of the underlined terms used in this form, see the Glossary at [www.carefirst.com/sbcg](http://www.carefirst.com/sbcg).
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service. For example, if the plan’s *allowed amount* for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the *allowed amount*. If an out-of-network **provider** charges more than the *allowed amount*, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the *allowed amount* is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Deductible; then 20% of Allowed Benefit for Acupuncture and Chiropractic Services</td>
<td>Deductible; then 20% of Allowed Benefit for Acupuncture and Chiropractic Services</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Retail Health Clinic</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>No charge</td>
<td>Some services may have limitations or exclusions based on your contract.</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>For services provided at an Outpatient Hospital Facility, a higher charge may apply</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% ($30 min/$45 max)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>25% ($60 min/$100 max)</td>
<td>30 day supply</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Copay waived if admitted Limited to Emergency Services or unexpected, urgently required services</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Deductible; then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Deductible, then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Prior authorization is required</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional professional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Deductible; then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Deductible, then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Prior authorization is required; Additional professional charges may apply</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional professional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Deductible; then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Deductible, then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Prior authorization is required; Additional professional charges may apply</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Deductible; then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Deductible, then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Additional professional charges may apply</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a Participating Provider</td>
<td>Non-Participating Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>Home Health Aide: 40 visits per benefit period</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>For treatment at an Outpatient Hospital Facility, an additional charge may apply Prior authorization is required after the first visit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Deductible; then 20% of Allowed Benefit and $150 per admission copay</td>
<td>Deductible, then 20% of Allowed Benefit and $150 per admission copay</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible, then 20% of Allowed Benefit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Deductible; then 20% of Allowed Benefit</td>
<td>Respite Care: 14 days per benefit period Bereavement: $100 maximum Family Counseling: $500 maximum</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$10 copay</td>
<td>Plan pays $33; Member pays balance</td>
<td>Limited to Members up to age 19; Limited to 1 visit/benefit period</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Discount program available to all members</td>
<td>Not covered</td>
<td>Limited to Members up to age 19; Limited to 1 set of glasses/ lenses per benefit period</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**Limited to Members up to age 19; Limited to 1 visit/benefit period**
### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover
(This isn’t a complete list. Check your policy or plan document for other excluded services.)

<table>
<thead>
<tr>
<th>Excluded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dental care</td>
</tr>
<tr>
<td>Long-term care</td>
</tr>
<tr>
<td>Routine foot care</td>
</tr>
<tr>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>

#### Other Covered Services
(This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Hearing aids</td>
</tr>
<tr>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Most coverage provided outside the United States. See <a href="http://www.carefirst.com">www.carefirst.com</a></td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Routine eye care</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage:

** Group health coverage—

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-628-8549. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [www.carefirst.com](http://www.carefirst.com) or 1-800-628-8549. You may also contact state consumer Assistance Program

- Maryland -1-800-492-6116 or [http://www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us)
- DC – 1-877-685-6391 or [www.disb.dc.gov](http://www.disb.dc.gov)
- Virginia – 1-877-310-6560 or [www.scc.virginia.gov/boi](http://www.scc.virginia.gov/boi)

For group health coverage subject to ERISA you may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6518

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-855-258-6518

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $12,840
- **Plan pays:** $11,300
- **Patient pays:** $1,438

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$8,100</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,400</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$200</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$900</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$100</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$12,840</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copays</td>
<td>$190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$688</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,438</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $7,460
- **Plan pays:** $5,840
- **Patient pays:** $1,555

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$4,060</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,700</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$1,100</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copays</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,555</strong></td>
</tr>
</tbody>
</table>

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.
### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

#### Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are **not** cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

---

**Can I use Coverage Examples to compare plans?**

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**

**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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**Questions:** If you are a member please call the number on your ID card or visit [www.carefirst.com](http://www.carefirst.com). Otherwise, please call 1-855-258-6518. If you aren’t clear about any of the underlined terms used in this form, see the Glossary at [www.carefirst.com/sbcg](http://www.carefirst.com/sbcg).
Foreign Language Assistance

English (English): Attention: 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.

Español (Spanish): Atención: 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 1-855-258-6518 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.

Ruština (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 можете 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 1-855-258-6518 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 निर्यात समय-सीमा के भीतर काम करना जरूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में न्यूज़लेटर पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 1-855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतिक्रिया करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएं और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàcso-wūdù (Bassa) To Đuù Càº: Bê niâte bá ny bê kê ni nga bá nìi fûa-fûa-tiin nèey jè dyi. Bê niâte bê ñé ñé wé jèê bê bê m ké dé wa m mà m ké nyuée nyu hwé bê bê bê ké zì. Jì mà ni kép bê m bê bê ni àa ké nga bá-pà-ká mà mààà nyà dé yé ni bût-wûti mû bê m ké dé wû diô péé. Koôkó nùu bê me dé àa-nũbà nià dé wàà L. kààà déè niin nèey. Nyo tò Déin nèey m dél nià Déi bê m bê bê ni nûbà mà 0 kér diyé pààjiin hwé. Dì jé ké nyo dò dyi m ôò jùn, ko wûu m mó po poa dyie, ko nyo dò mu bò niin bê c ké ni wûu mà zà.

বাংলা (Bengali) লক্ষ্য করলে: এই নোটিশ আপনার বিষয়ে কভারেজ সম্পর্কে তথ্য দেয়। এর মধ্যে গ্রাহকগণ তারিখের লক্ষ্য পেলে এবং নিঃসন্দেহ তারিখের মাধ্যমে আপনার পরিসংখ্যান ভাষায় এই অপারেইশন এবং সহায়তা প্রদানের অধিকার আছে। সদস্যদেরকে ভাষা পরিবর্ধনের পাঠ্য থাকা নমুনা রূপে করতে হবে। অল্প (1-855-258-6518 নমুনা কো 0 তিজুত না বলা পর্যালোচনা করতে হবে। যখন কোনো এজেন্ট উত্তর দেন তখন আপনার নিষিদ্ধ ভাষার নাম বলন এবং আপনাকে দোভাষীর স্পেস সংযুক্ত করা হবে।

اردو (Urdu) توجه: پہ نوشا آپ کو انٹرینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخی یا سکتی پین اور میکن بے کی آ پ کو مخصوص ایک تاریخ کی کارونی کنی کی مصروف پڑی۔ آپ کے پر معلومات حاصل کریں اور غیر خرچی کی اپنی زبان میں حاصل کریں یا ہے۔ ممکن ہے کہ مبنی پر موجود فون نمبر پر کال کرنی چاہئے۔ سبھی میگر لوگ 6518-1-855-258-6518 پر کال کر سکتے ہیں یا کو ہی طریقے پر مربوطہ پانیکدی ہو جائے گی یا پر مربوطہ پانیکدی ہو جائے گی۔

فارسی (Persian) توجه: این اعلامیه‌ها اطلاعاتی درباره پوشش بیمه شما است. ممکن است این تاریخ‌ها مهم به شما است ویا است که تاریخ‌های مهم به شما است. ممکن است این اطلاعات به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شما، به شماره (Arabic) اللغة العربية (Arabic) تتطلب يحيى هذا الإخطار على معلومات بشأن تعديلات الاستثنائية، و يحتوي على توازية مهمة، وقد تحتاج إلى إتخاذ إجراءات بحلول مواعيد نهاية محددة. يحق له التحول على هذه الملاحظات والعلومات ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة ببكل دين تحمل كل كفتة B. 6518-1-855-258-6518 والإخطار خالص المحايدة حتى يطلب منهم الضغط على رقم، عند إعداد أحد الوقاية، إذن اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحدث 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些資訊，以及透過您的母語的提供的協助服務。會員請撥打在身分識別卡背面的電話號碼。其他所有人士可撥打電話 1-855-258-6518，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絡。
Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. Ọ nwere ike inwe ụbọchị ndị mkpa, ị nwere ike jine ihe tupu ufo dị ụbọchị njedebe. Ị nwere ika to n'ụzọ enywọ mkpuchi n'akwụgu ụgwọ ọ bụla. Ndị otu kwesịjị ikpọ akara ekwenti dị n'azı nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ika n'ụgbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnochịte anya zara, kwuo asusu i chọrọ, a ga-ejiko gi na onye okwu 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 +1 844 438 6482 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 1-855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.