Catastrophic Health Expense Program Claim Form

(Grandfathered)

IMPORTANT
By submitting this document, you acknowledge that it is your intent to initiate and/or apply claims to a Catastrophic Deductible Period and/or request benefits under an established Catastrophic Benefit Period in accordance with your CareFirst BlueCross BlueShield (CareFirst) Catastrophic Health Expense Program policy. **PLEASE BE SURE TO READ PAGES 3 THROUGH 5 BEFORE COMPLETING FORM.**

INFORMATION		
Catastrophic Membership Number		
Patient's Last Name	First Name	MI
Patient's Date of Birth (mm/dd/yyyy) / /	Patient's Gender Male Female	
Relationship to Policyholder Self Spouse Child	Home Phone Number	
Policyholder's Last Name	First Name	MI
Home Street Address		
City	State	ZIP

ALL THE FOLLOWING QUESTIONS MUST BE ANSWERED	
1. Is this your first Catastrophic Health Expense Program claim? Yes No If no, what was the date of your most recent claim? / /	
2. Illness(es) or injury(ies): A. B. C.	Date of first symptom(s): A. / / B. / / C. / /
3. To be completed by patient regardless of age: Is the patient entitled to benefits under Medicare Insurance Part A (Hospital)? Yes No Effective date of coverage: / / Is the patient entitled to benefits under Medicare Insurance Part B (Physician)? Yes No Effective date of coverage: / / Medicare Number:	

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ALL THE FOLLOWING QUESTIONS MUST BE ANSWERED

4. In addition to coverage under this Program, is the patient covered under any health insurance plan providing health care benefits or service? Yes No

If Yes, please complete the following information:

A. Name of policyholder:	
Name and address of insuring company:	
Check type of coverage: Hospital Surgical-Medical Major Medical Other (Specify)	
Effective date of coverage:	Policy number:

B. Name of policyholder:	
Name and address of insuring company:	
Check type of coverage: Hospital Surgical-Medical Major Medical Other (Specify)	
Effective date of coverage:	Policy number:

Name of policyholder:	
Name and address of insuring company:	
Check type of coverage: Hospital Surgical-Medical Major Medical Other (Specify)	
Effective date of coverage:	Policy number:

Name of policyholder:	
Name and address of insuring company:	
Check type of coverage: Hospital Surgical-Medical Major Medical Other (Specify)	
Effective date of coverage:	Policy number:

SIGNATURE

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization named above. Authorization is hereby given to any hospital, physician or other provider which participated in any way in my care and treatment to release to the CareFirst BlueCross BlueShield plan any medical information which they in their judgement deem necessary to the adjudication of this claim.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Policyholder Signature	Date

Instructions on How to File a Claim

When do I submit my claim?

- Submit your claim after you have met your $50,000 deductible within a consecutive 12-month period.
- You must submit your claim no later than December 31 of the year following the year in which the service was rendered.

What do I submit with my claim?

- A new and completed Catastrophic Health Expense Program Claim Form, which must accompany each claim or group of claims submission.
- An **acceptable** itemization of charges.
- An Explanation of Benefits (EOB) from your primary insurance plan(s), including your Medicare Summary Notice, if you have Medicare. Your primary plan/Medicare EOB is required even if the benefits are exhausted.

What is an acceptable itemization of charges?

- **Professional charges (physician/specialist, durable medical equipment (DME) supplier, laboratory, ambulance)—the preferred acceptable itemization of Professional charges is a CMS 1500 form. A CMS 1500 is the standard billing form professional providers use to bill insurance companies.** You can call the billing department of the provider who rendered the service and request a CMS 1500 for your charges.
- **Institutional charges (hospital, ambulatory surgery center, skilled nursing facility, home health agency, hospice)—the preferred acceptable itemization of Institutional charges is a UB04 form. A UB04 is the standard billing form institutional providers use to bill insurance companies.** You can call the billing department of the facility where the service was rendered and request a UB04 for your charges.

If you are unable to obtain a CMS 1500 or UB04, or they are not applicable (i.e., pharmacy charges), an itemized bill is acceptable. Your itemized bill must be on the letterhead of the provider or facility that rendered the service **and** contain specific required information. **See attached examples for the minimum requirements for an itemized bill.**

After an initial review of the claim, it may be necessary to request additional information before a final benefit determination can be made. **It is the policyholder's responsibility to provide additional information requested.**

Note: If claims are submitted for more than one family member at a time, a separate claim form and separate itemization of charges must be submitted for each family member.

What is NOT an acceptable itemization of charges?

Cancelled checks, cash register slips, invoices, balance forward and activity statements and personal itemizations are not acceptable itemizations of charges and must not be sent to CareFirst.

Where do I submit my claim?

Submit your completed Catastrophic Health Expense Program Claim Form, acceptable itemization of charges (CMS 1500, UB04 or itemized bill), Explanation of Benefits from your primary insurance plan(s), including your Medicare Summary Notice (if you have Medicare) and any other documentation of charges to:

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115

Note: Your bills cannot be returned to you. Please make and retain photocopies for your records before submitting your claim.

Who do I contact if I have questions?

If you have any questions or need a Catastrophic Health Expense Program Claim Form, please call Member Services at 888-567-9890.

Professional Provider/Supplier Itemized Bill Example

Professional (e.g., physician/specialist, DME supplier, laboratory, ambulance) itemized bills must include:

1. Rendering provider name, address, phone number, tax ID number (9 digits) and NPI (10 digits)
2. Patient name and date of birth
3. Date of service
4. Description of place of service (POS) or POS Code
5. Description of service or procedure code (CPT)
6. Description of diagnosis or diagnosis code (ICD-10)
7. Separate charge for each service
8. Total charge
9. Rendering provider signature

- **If durable medical equipment (DME) or medical supplies—delivery location is required**
- **If lab, X-ray—ordering physician name, address, phone number, tax ID, NPI and signature is required**
- **If mental health, physical, occupational or speech therapy—length and type of session is required**

(1) **Dr. J. R. Barnes**
200 Market St.
New Town, MD 11111
NPI: 1122334455 Tax ID: 123456789

For Professional Services to: Rosa L. Jones (2) Date of Birth: 11/12/1954

Date of Service (3)	POS	Procedure (CPT)	Reason/ Diagnosis (6)	Charge
8/8/2018	30 (4)	Office Visit 99215 (5)	H92.09	$75.00
8/12/2018	30	Office Visit 99213	H92.09	$50.00 (7)
11/15/2018	30	Office Visit 99215	H92.09	$75.00

TOTAL CHARGES: $200.00 (8)

(9) Physician Signature: Joseph Ray Barnes, M.D.

* Examples are for illustrative purposes only. The policyholder is required to provide additional information if needed.

Institutional Provider Itemized Bill Example

Institutional (e.g., hospital, ambulatory surgery center, skilled nursing facility, home health care agency, hospice) itemized bills must include the following information:

1. Facility name, address, tax ID number (9 digits) and NPI (10 digits)
2. Insured's name and identification number
3. Patient name, address, date of birth, gender and relationship to insured
4. Patient control number
5. Type of bill
6. Admission date/time, source, type and admitting diagnosis code (if applicable)
7. Discharge date/time and patient discharge status (if applicable)
8. Dates of service, statement covers period
9. Revenue code and description
10. Condition, occurrence and value codes (if applicable)
11. Units of service
12. Diagnosis code
13. Attending physician name and identification number
14. Payer identification
15. Total charges by revenue code

Itemized Statement of Facility Charges

University Hospital
888 Market St
New Town, MD 11111 (1)
(443) 555-9999

TaxID: 222333444
NPI: 5555566666

Date of Bill: 7/12/18

Page No.: 1 of 3

(4) **Patient Control Number:** 12345abcde

Patient Name—Address	Sex	Date of Birth	Admission Date/Time		Discharge Date/Time		Condition—Occurrence—Value—Code/Dates
Rosa L. Jones 111 Park Place New Town, MD, 11112 (3)	F	7/12/1954	6/30/2018 11:51am (6)		7/2/2018 2:23pm (7)		
Patient Relationship: Self	**Type of Bill:** (5)	113	**Admission Type/Source**	2 / Emergency Room	**Discharge Status:**	01	(10)

Insurance Company Name			Group Number	(14) Policy Number
Any Health Insurance Company			XYZ4U	123456789
Guarantor Name and Address	Rosa L. Jones 111 Park Place New Town, MD 11112 (2)	**Guarantor ID Number:**	XXX987654321 (11)	**Statement Covers Period:** 6/30/2016–7/2/2016 (8)

Date	Description	Revenue Code	Quantity	Unit Price	(15) Total Charges	Diagnosis (Principal/Admitting)
6/30/2018	Room 10 I (9)	202	1	$1,972.00	$1,972.00	786.59 (12)
7/1/2018	Room 10 I	202	1	$1,972.00	$1,972.00	
7/2/2018	Room 73 T	206	1	$1,962.00	$1,962.00	
6/30/2018	Sodium Chloride IV 100 ml	250	300	$0.03	$8.82	
7/1/2018	Chest Frontal Single View	324	1	$97.24	$97.24	

Total Charges: $6,012.06

(13)
Attending Physician: Dr. J.R. Barnes
NPI: 1122334455

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Pharmacy Itemized Bill Example

Prescription drug itemized bills must include the following information:

1. Pharmacy name, address and telephone number
2. Full name of patient
3. Date of purchase
4. Drug name, dosage and quantity
5. National drug code (NDC) (11 digits)
6. Separate charge for each prescription
7. Prescribing doctor name, tax ID and NPI
8. Pharmacist signature

Price Pharmacy
200 Market St.
New Town, MD 111111 (1)

(443) 555-1234

Pharmacist: Dr. John A. Price (8)

Patient: Rosa L Jones (2)

Date	Drug (4)	NDC (5)	Charge (6)	Doctor (7)
Date: 8/8/18 (3)	Amoxicillin (10) 875 mg	1912-2116-08	$2.75	Dr. George Smith TaxID:111111111 NPI: 2222222222
Date: 8/8/18	Synthroid (90) 0.1 mg	1912-2116-08	$14.95	Dr. J. R. Barnes TaxID:555111333 NPI: 1122334455
Date: 10/16/18	Amoxicillin (10) 875 mg	3579-5512-58	$1.40	Dr. George Smith TaxID:111111111 NPI: 2222222222
			Total: $19.10	

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CUT0058-4S (12/18)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

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**.

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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-fûá-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 fûùn-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 mɔ̀à 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'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ́ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyį́įlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'į́įh. 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' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.