Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
and
CareFirst BlueChoice, Inc. (CareFirst BlueChoice)
840 First Street, NE
Washington, DC 20065
202-479-8000

Independent licensees of the Blue Cross and Blue Shield Association

Insurers identified above are responsible for the obligations in this Group Contract Application.

Point-of-Enrollment

GROUP CONTRACT APPLICATION

Point-of-Enrollment is jointly offered product(s) from CareFirst and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) (collectively referred to as CareFirst/CareFirst BlueChoice). With Point-of-Enrollment product(s), the Subscriber may select for himself/herself and his/her dependents a CareFirst or a CareFirst BlueChoice product offered by the Group each year. Except when a special enrollment provision may be applicable, the Subscriber is locked into the selected product until the next Annual Open Enrollment Period, at which time the Subscriber can elect to change to another product. There are two additional exceptions. If the Subscriber lives outside of the CareFirst BlueChoice Service Area, has chosen a CareFirst product and subsequently moves into the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst BlueChoice product within 60 days of residing in his/her new residence. This would only be applicable for a CareFirst BlueChoice product with a residency requirement. Additionally, if the Subscriber has chosen a CareFirst BlueChoice product with a residency requirement, and moves out of the CareFirst BlueChoice Service Area, then the Subscriber may, with proof of new residence, change to a CareFirst product, or CareFirst BlueChoice product that does not have a residency requirement, within 60 days of residing in his/her new residence. Any change caused by new residence will take effect on the first day of the month following notification to CareFirst/CareFirst BlueChoice of the change.

If this Application is being completed for a new Group, or an existing Group selecting a new product or making a jurisdictional change, the Group is required to complete this Application in its entirety, in black ink, and sign, date and return it to the Group's Sales Representative.

If this Application is being completed for an existing Group amending the Group's current coverage or changing general information, the Group is required to complete, in black ink, *only* the sections in which the information is changing, sign, date and return this Application to the Group's Sales Representative.

Do not alter this document except to fill in the blanks and check the boxes provided. This Application will not be accepted if any other changes are made.

GENERAL INFORMATION

Group Number (if available): _____

Name of Organization: _____

Physical Location:

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Billing Address (if other than above):

Street Address: _____

City: _____ State: _____ Zip: _____

Group Administrator (Person to Contact):

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Chief Executive Officer/President

Name: _____ Telephone Number: _____

Title: _____

Email Address: _____

Type of Organization ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____

Nature of Business: _____

Federal Tax Identification Number: _____

EMPLOYER CONTRIBUTION

Medical Products
CareFirst/CareFirst BlueChoice reserves the right to revise rates, or to refuse to renew any CareFirst/CareFirst BlueChoice health benefit plan issued to the Group, if the Group does not contribute an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees.

CareFirst/CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change.

Freestanding Dental and Vision Products
To be eligible for CareFirst Group dental and/or vision benefits coverage, the employer must identify the contribution level that applies to the dental and/or vision benefits coverage in the checkboxes below. If the employer's contribution for enrolled employees is an amount equal to at least 50% of the cost of the Individual Coverage for enrolled employees, then the employer should select employer-sponsored below. If the employer's contribution is less than 50% of the cost of the Individual Coverage, the plan will be considered Voluntary, and the employer should select Voluntary below. If the employee or participant in the Group agrees to pay the entire premium for the coverage to the Group, then the employer should select Voluntary below.

If the Group selects dental benefit coverage, the Group must specify if the coverage will be:

☐ Employer-sponsored or
☐ Voluntary

If the Group selects vision benefit coverage, the Group must specify if the coverage will be:

- ☐ Employer-sponsored or
- ☐ Voluntary

GROUP MINIMUM ENROLLMENT REQUIREMENTS

Medical Benefits Products- Minimum Enrollment Requirements:
If the employer does not meet the following requirements, CareFirst/CareFirst BlueChoice reserves the right to revise rates, or to refuse to renew any CareFirst/CareFirst BlueChoice health benefit plan issued to the Group:

Groups must enroll and maintain enrollment of 75% of all employees eligible for medical coverage (or 100% if the employer pays the entire Individual Coverage premium). If there are less than 75% enrolled in any of medical health benefits products offered by the Group, CareFirst/CareFirst BlueChoice reserves the right to revise the rates for the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

This must be the sole health plan offered by the Group to its employees.

If at any time total enrollment increases or decreases by 10% or more, CareFirst/CareFirst BlueChoice reserves the right to revise the rates at renewal or to refuse to renew any of the medical health benefits products offered by the Group.

The Group cannot enroll in HMO programs (other than CareFirst BlueChoice, Inc.) more than 25% of the total number of employees enrolled in all health programs offered through the Group. If applicable, the Group cannot continue to enroll new employees in a staff model HMO.

The basis for determining whether an enrollment increase or decrease has occurred will be the total enrollment

1. For purposes of renewal: On the contract renewal date versus the total enrollment proposed at the time the rates were developed.

2. For premium rate adjustments: On the first day of any month during the contract period versus the total enrollment proposed at the time the rates were developed.

CareFirst/CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change. If, however, the proposed premium rate increase exceeds thirty-five percent (35%) of the annual premium charged, CareFirst/CareFirst BlueChoice will give the Group prior written notice of no less than sixty (60) days.

Freestanding Dental and Vision Products- Minimum Enrollment Requirements:
When a Group selects employer-sponsored freestanding dental and/or vision benefit coverage, the Group must enroll and maintain enrollment of at least 75% of all eligible employees for the employer-sponsored dental and/or vision coverage. If at any time there are less than 75% enrolled in the employer-sponsored dental and/or vision products; CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the 75% requirement, or refuse to renew the product that does not meet the 75% requirement.

When a Group selects Voluntary dental benefit coverage, the Group must enroll and maintain enrollment of 20% of all employees eligible for the Voluntary dental coverage. If at any time there are less than 20% enrolled in the Voluntary dental coverage, CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate the product that does not meet the 20% requirement, or refuse to renew the product that does not meet the 20% requirement.

If the Group offers dental or vision benefits only and at any time total enrollment increases or decreases by 10% or more, CareFirst/CareFirst BlueChoice reserves the right to rescind the proposal (if prior to effective of the applicable Group Contract), revise the rates, terminate this Group Contract, or refuse to renew this Group Contract.

The basis for determining whether an enrollment increase or decrease has occurred will be the total enrollment

1. On the effective date or contract renewal date versus the total enrollment proposed at the time the rates were developed; and

2. On the first day of any month during the contract period versus the total enrollment proposed at the time the rates were developed.

CareFirst/CareFirst BlueChoice will notify the Group of any rate adjustments no later than 45 days prior to the effective date of the rate change. If, however, the proposed premium rate increase exceeds thirty-five percent (35%) of the annual premium charged, CareFirst/CareFirst BlueChoice will give the Group prior written notice of no less than sixty (60) days.

Other Minimum Enrollment Requirements Applicable to All Products:
At least one employee must be employed full-time and enrolled under the Group's coverage on the first day of the plan year. (Note: Those employees with complementary to Medicare coverage do not count toward the one employee minimum enrollment requirement.) Enrolled Groups that drop to less than one full-time employee at this time should contact their CareFirst/CareFirst BlueChoice Sales Representative to arrange for individual direct pay coverage.

Exclusions from Minimum Enrollment Requirements (Applicable to All Products):
The following eligible employees should be excluded from the above counts:

1. Those eligible employees who have coverage under their spouse's or parent's group coverage; TRICARE; Medicare as primary under TEFRA; or their prior employer's plan under COBRA.

2. Those eligible employees enrolled in other CareFirst/CareFirst BlueChoice coverage or covered under any CareFirst affiliate.

Annual Enrollment Certification:
CareFirst/CareFirst BlueChoice reserves the right to inspect the records of the Group after sixty (60) days from the effective date of the Group coverage in order to verify the eligibility of employees and their dependents. In addition, the Group may be required to complete and return to CareFirst/CareFirst BlueChoice an eligibility audit and/or census report annually.

EMPLOYEE ELIGIBILITY REQUIREMENTS

The following individuals identified below ("Subscribers") are eligible to enroll themselves (and any dependents), as long as they meet the additional eligibility and enrollment requirements stated in the Evidence of Coverage and any attachments thereto.

Full-Time Employees: All employees (including owners and partners) who are regularly employed on a full-time basis working at least 30 hours a week on a regular basis. Seasonal employees and independent contractors, such as subcontractors, who received a 1099, are not eligible to enroll. The IRS has issued guidance on when individuals could be treated as either an employee or independent contractor. Employers are encouraged to review this guidance and consult with an attorney or accountant, if needed.

All former employees (and any dependents), enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements.

Specify the following additional Subscribers that the Group wishes to cover, even if the Group does not currently have such individuals in the Group. NOTE: These individuals cannot be included in the total number of eligible employees for the Group.

☐ Part-time employees who works at least 17.5 hours per week for more than six months each year.

☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retired prior to the effective date of this coverage. (Available only if covered under the Group's prior health coverage)

☐ All Retirees in accordance with the provisions of the Group's retirement program, as amended from time to time, who retire on or after the effective date of this coverage.

☐ All former employees who terminated employment due to disability prior to the effective date of this coverage may enroll for a period of not more than 2 years. (Available only if covered under the Group's prior health coverage.)

☐ All eligible individuals who terminate employment due to disability after the effective date of this coverage may enroll for a period of not more than 2 years.

☐ Other _____(Specify)

Note: No individual is eligible to enroll under the Group's coverage both as a Subscriber and as a dependent. If the Group employs both spouses of a family (or both Domestic Partners, if applicable), they may not both select a Type of Coverage that is Individual and Adult Coverage or Family Coverage.

DOMESTIC PARTNER ELIGIBILITY

Specify below whether Domestic Partners of Subscribers will be eligible to enroll as dependents.

☐ YES ☐ NO Domestic Partners of Subscribers are eligible

ENROLLMENT EFFECTIVE DATES

Coverage of the following eligible individuals becomes effective on the date that the Group Contract becomes effective:

1. Existing eligible individuals who are currently enrolled under the Group's prior health coverage;

2. Former employees, who are currently enrolled under the Group's prior health coverage, whose eligibility for group coverage has been extended due to COBRA requirements; and

3. Eligible individuals who enroll during an open enrollment period prior to the effective date of the Group Contract.

Coverage for an individual newly eligible to enroll as a Subscriber, and any eligible and enrolled dependents, is effective as stated below:

Select one:

☐ On the first day of the month following employment or eligibility, whichever is later.

☐ On the date of employment or eligibility, whichever is later.

☐ On the day after the Subscriber satisfies the Group's Waiting Period of ____ days after employment or eligibility, whichever is later. (Day range cannot exceed a total of ninety (90) days)

☐ On the first day of the month following the Subscriber satisfies the Group's Waiting Period of ____ days after employment or eligibility, whichever is later. (Day ranges cannot exceed a total of sixty (60) days to ensure compliance with applicable law).

☐ Other _____ (Specify).

TERMINATION OF COVERAGE

Coverage for enrolled Subscribers and/or their enrolled Dependents who are no longer eligible (other than on the basis of a dependent child's limiting age) terminates on the date stated below:

Select One:

- ☐ The date on which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.
- ☐ The last day of the month in which the Subscriber's employment or eligibility or the Dependent's eligibility terminates.
- ☐ Other _____ (Specify).

AGE LIMITS FOR DEPENDENT CHILDREN

Dependent children are covered until:

Select One:

- ☐ The last day of the month of their 26th birthday.
- ☐ On the date of their 26th birthday
- ☐ The last day of the calendar year of their ____ birthday. (Specify an age over the age of 26.)
- ☐ The last day of the month of their ____ birthday. (Specify an age over the age of 26.)
- ☐ On the date of their ____ birthday (Specify an age over the age of 26.)

Dependent students may remain eligible after the age selected above as long as they are enrolled as full-time students in an institution and students over age 26 must have a student certification on file with CareFirst until:

Select One:

- ☐ The last day of the month of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The date of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The last day of the calendar year of their ____ birthday. (Specify an age of 27 or over.)
- ☐ The last day of the month of the student dependent's graduation or the end of the month of their ____ birthday, whichever occurs last. (Specify an age of 27 or over.)
- ☐ The last day of the calendar year of the student dependent's graduation or the last day of the calendar year of their ____ birthday, whichever occurs last. (Specify an age of 27 or over.)

Note: Dependent eligibility must end in the same manner for dependent children and dependent students, i.e. at the end of the year, or the end of the month, or on the birthday. For example, the Group may not select end of the month for dependent children and end of the year for dependent students.

GROUP'S RESPONSIBILITY TO EMPLOYEES

In any case in which the employee is responsible for a portion of the monthly premiums, the Group must:

1. Advise the employee of his/her eligibility for coverage under the Group Contract;

2. Advise the employee when s/he may enroll for such coverage in accordance with the provisions stipulated in this Application and the Group Contract including the Evidence of Coverage;

3. Advise the employee when coverage will commence based on the aforementioned provisions and the date of completion of the enrollment form;

4. Advise the employee of the cost of such coverage to the employee and the method in which payment is to be made; and

5. Obtain from the employee a completed enrollment form and a signed agreement by the employee to pay the applicable portion of the monthly rates.

GROUP STATEMENTS

The Group agrees that in the making of this Application, it is acting for and on behalf of itself and as the agent representative of its employees and COBRA participants, and their dependents; and it is agreed and understood that the Group is not the agent or representative of CareFirst/CareFirst BlueChoice for any purpose of this Application or any Group Contract issued pursuant to this Application.

The Group agrees to receive on behalf of its eligible employees, COBRA participants, and their dependents, the Evidence of Coverage including all attachments, and all relevant notices furnished by CareFirst/CareFirst BlueChoice, and to forward such materials to these individuals.

The Group agrees that in the making of this Application, it has provided CareFirst/CareFirst BlueChoice with information regarding the eligibility of employees (and their dependents) that is accurate and consistent with the requirements and provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C).

This Group Contract Application is part of the Agreement between the Group and CareFirst/CareFirst BlueChoice.

IMPORTANT NOTE: The Group's rate sheet which describes the benefits and corresponding rates for the CareFirst/CareFirst BlueChoice coverage selected must be signed by the Group before coverage can be made effective. CareFirst/CareFirst BlueChoice reserves the right to revise the rates if the actual enrollment varies substantially from that used in the original rating or if applicable law or regulatory authority requires such revisions.

Warning: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia state law.

ACCEPTED FOR:

_____
(Name of Organization)

BY: _____
(Printed Name of Authorized Officer)

_____
(Signature of Authorized Officer)

Title: _____ Date: _____

Broker (if applicable)

_____

(Printed Name of Broker)

_____

(Signature of Broker)

Email Address: _____

Date: _____

Effective Date of Group Contract: _____

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 14858 Lexington, KY 40512
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.

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their identification card. All others may call 1-855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

ማሳሰቢያ (Amharic)፦ ይህ ማሳወቂያ ስለ ኢንሹራንስ ሽፋንዎ መረጃ ይዟል። ቁልፍ ቀኖችን ሊይዝ ይችላል እና በተወሰኑ የግዜ ገደቦች እርምጃ መውሰድ ሊኖርብዎ ይችላል። ይህን መረጃ እና እገዛ ያለ ምንም ወጪ በቋንቋዎ የማግኘት መብት አለዎት። አባላት በአባላት መታወቂያ ካርዳቸው ጀርባ ወዳለው ስልክ ቁጥር መደወል አለባቸው። ሌሎች በሙሉ ወደ 855-258-6518 በመደወል 0ን እንዲጫኑ እስኪጠየቁ ድረስ ምልልሱን መጠበቅ ይችላሉ። አንድ ወኪል ሲመልስ፣ የሚፈልጉትን ቋንቋ ይግለጹ እና ከአስተርጓሚ ጋር ይገናኛሉ።

انتبه (Arabic): يحتوي هذا الإشعار على معلومات حول تغطيتك التأمينية. قد يحتوي على تواريخ رئيسية وقد تحتاج إلى اتخاذ إجراء بحلول مواعيد نهائية معينة. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. يجب على الأعضاء الاتصال برقم الهاتف الموجود على ظهر بطاقة هوية العضوية الخاصة بهم. يمكن للآخرين الاتصال بالرقم 855-258-5618 والانتظار طوال الحوار حتى يُطلب منهم الضغط على الرقم 0. عندما يجيبك أحد الوكلاء، حدد اللغة التي تحتاجها وسيتم توصيلك بمترجم فوري.

মনোযোগ দিন (Bengali): এই বিজ্ঞপ্তিতে আপনার বীমা কভারেজ সম্পর্কে তথ্য রয়েছে। এতে গুরুত্বপূর্ণ তারিখগুলি থাকতে পারে এবং আপনাকে হয়ত নির্দিষ্ট সময়সীমার মধ্যে পদক্ষেপ নিতে হতে পারে। আপনার ভাষায় বিনামূল্যে এই তথ্য এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদের তাদের সদস্য পরিচয়পত্রের পিছনে দেওয়া ফোন নম্বরে কল করা উচিত। অন্যরা 855-258-6518 নম্বরে কল করতে পারেন এবং 0 চাপ দেওয়ার জন্য অনুরোধ না করা পর্যন্ত সংলাপের জন্য অপেক্ষা করতে পারেন। যখন একজন এজেন্ট উত্তর দেবেন, তখন আপনার প্রয়োজনীয় ভাষাটি বলুন এবং আপনাকে একজন দোভাষীর সাথে সংযুক্ত করা হবে।

注意（Chinese）：此通知包含有關您的保險範圍的資訊。它可能包含關鍵日期，您可能需要在特定截止日期之前採取行動。您有權免費以您的語言獲取此資訊和協助。會員應撥打會員證背面的電話號碼。其他所有人可以撥打 855-258-6518 並等待對話框，直到提示按 0。當代理商接聽時，請說明您需要的語言，然後您将會與翻譯人員聯繫。

توجه (Farsi): این اطلاعیه حاوی اطلاعاتی درباره پوشش بیمه‌ای شما است. ممکن است شامل تاریخ‌های مهم باشد و لازم باشد تا مهلت‌های مشخصی اقدام کنید. شما حق دارید این اطلاعات و کمک را به زبان خود و به‌صورت رایگان دریافت کنید. اعضا باید با شماره تلفن درج‌شده در پشت کارت شناسایی عضویت خود تماس بگیرند. سایر افراد می‌توانند با شماره *855-258-6518* تماس بگیرند و منتظر بمانند تا دستور داده شود که عدد 0 را فشار دهند. هنگامی که یک نماینده پاسخ داد، زبان مورد نیاز خود را اعلام کنید تا به یک مترجم متصل شوید.

Attention (French): Le présent avis contient des informations essentielles relatives à votre couverture d’assurance. Il peut inclure des échéances importantes nécessitant une action de votre part dans un délai déterminé. Vous avez le droit d’obtenir ces informations ainsi qu’une assistance dans votre langue, et ce, sans frais. Les assurés sont invités à contacter le numéro figurant au verso de leur carte d’adhérent. Toute autre personne peut appeler le 855-258-6518 et patienter jusqu’à l’invitation à composer le 0. Lorsque votre appel sera pris en charge, indiquez la langue souhaitée afin d’être mis en relation avec un interprète.

Achtung (German): Dieser Hinweis enthält Informationen zu Ihrem Versicherungsschutz. Darin sind möglicherweise wichtige Termine aufgeführt und Sie müssen möglicherweise bis zu bestimmten Fristen Maßnahmen ergreifen. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Mitglieder sollten die Telefonnummer auf der Rückseite ihres Mitgliedsausweises anrufen. Alle anderen können 855-258-6518 anrufen und den Dialog abwarten, bis sie aufgefordert werden, die 0 zu drücken. Wenn ein Agent antwortet, geben Sie die gewünschte Sprache an und Sie werden mit einem Dolmetscher verbunden.

ध्यान दें (Hindi): इस नोटिस में आपके बीमा कवरेज के बारे में जानकारी है। इसमें महत्वपूर्ण तिथियां हो सकती हैं और आपको निश्चित समय सीमा तक कार्रवाई करनी पड़ सकती है। आपको यह जानकारी और सहायता अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सदस्यों को अपने सदस्य पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और 0 दबाने का संकेत मिलने तक संवाद की प्रतीक्षा कर सकते हैं। जब कोई एजेंट उत्तर दे, तो वह भाषा बताएं जिसकी आपको आवश्यकता है और आपको दुभाषिया से जोड़ा जाएगा।

Leruoanya (Igbo): ọ́kwà a nwere ozi bànyéré mkpuchi megide ihe mberede gị. Ọ nwere ike inwe ụbọchị ndi dị óké ḿkpà ma o nwekwara ike idị mkpa ka imee ihe tupu oge ụfọdụ agafee. Inwere ikike inweta ozi a ya na enyemaka na asụsụ gị n'akwụghị ụgwọ ọbụla. Ndi òtù ga akpọ ọnụọgụgụ ekwenti dị na àzụ́ ḱáàdị njirimara ndi òtù ha. Ndi ọ̀zọ́ nile nwere íke ịkpọ 855-258-6518 ma chere geruo mkparịta ụka ruo mgbe asi ha pịa 0. Mgbe onye ozi zara,kwuo asụsụ ichọrọ, a ga ejikota gi na onye ntughari asụsụ.

Attenzione (Italian): Questa informativa contiene informazioni sulla copertura assicurativa. Potrebbe contenere date importanti e potrebbe essere necessario intraprendere azioni entro determinate scadenze. È possibile ottenere queste informazioni e assistenza nella propria lingua gratuitamente. I membri sono pregati di chiamare il numero di telefono riportato sul retro del proprio tesserino di riconoscimento. Tutti gli altri possono chiamare il numero 855-258-6518 e rimanere in linea fino a quando non viene richiesto di premere 0. Quando un operatore risponde, è necessario indicare la lingua desiderata per essere messi in contatto con un interprete.

주의 (Korean): 이 고지에는 귀하의 보험 적용 범위에 대한 정보가 포함되어 있습니다. 여기에는 주요 날짜가 포함되어 있을 수 있으며, 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하는 비용 없이 귀하의 언어로 이러한 정보와 지원을 받을 권리가 있습니다. 회원은 회원증 뒷면에 있는 전화번호로 전화하시기 바랍니다. 회원이 아닌 모든 분들은 855-258-6518 로 전화하여 안내 메시지가 끝날 때까지 기다렸다가 0 을 눌러주세요. 상담원이 통화에 응답했을 때, 필요한 언어를 말씀하시면 통역사와 연결됩니다.

Baa'ákonínízin (Navajo): Díí bee ił hane'í béeso nich'ą́ąh naa'nil bee nik'é'asti'í bódahólníihgo bee baa dahane'í biyi'. Dayoołkáłí dóó bee ida'ii'aahí háídíí shį́į́ t'áá bich'į'jį' ha'át'íishį́į́ ádadiiliiłígíí biyi'. Díí bee baa dahane'í dóó t'áá jiik'eh nizaad bee nika'e'eyeedgo bee ná'ahoot'i'. Bił hada'dít'éhí binaaltsoos nitł'izhí bee béédahóziní bąąh béésh bee hane'í námboo biká'ígíí yee dahalne' dooleeł. Nááná ła' 855-258-6518 yee dahalne' dóó yáłti'í biba' asdáago niléí ó bił adílchíid hodoo'niidjį'. Naalnishí haadzį́į'go, saad nínízinígíí bee bił hodíilnih dóó ata' yáłti'í bich'į' ni'doolnih.

ध्यान दिनुहोस् (Nepali): यस सूचनामा तपाईंको बीमा कभरेजका बारेमा जानकारी समावेश छ। यसमा प्रमुख मितिहरू हुन सक्छन् र तपाईंले निश्चित समयसीमा भित्र कारबाही गर्नुपर्ने हुन सक्छ। तपाईंलाई यो जानकारी र सहयोग तपाईंको भाषामा निःशुल्क प्राप्त गर्ने अधिकार छ। सदस्यहरूले आफ्नो सदस्य परिचयपत्रको पछाडि रहेको फोन नम्बरमा कल गर्नुपर्छ। अरू सबैले 855-258-6518 मा कल गर्न सक्छन् र ० पुश गर्न प्रेरित नभएसम्म संवादको प्रतीक्षा गर्न सक्छन्। एजेन्टले जवाफ दिँदा, तपाईंलाई चाहिने भाषा बताउनुहोस् र तपाईंलाई दोभाषेसँग जोडिने छ।

Atenção (Portuguese): Este aviso contém informações sobre a cobertura do seu seguro. Ele pode conter datas importantes e você pode precisar tomar medidas dentro de determinados prazos. Você tem o direito de obter essas informações e assistência em seu idioma, sem nenhum custo. Os associados deverão ligar para o número de telefone indicado no verso do seu cartão de identificação de associado. Todos os outros podem ligar para 855-258-6518 e aguardar a mensagem até que seja solicitado a pressionar 0. Quando um agente atender, indique o idioma que você precisa e você será conectado a um intérprete.

Внимание (Russian): В настоящем уведомлении содержится информация о вашем страховом покрытии. Оно может содержать ключевые даты, и вам может потребоваться предпринять действия к определенным срокам. Вы имеете право получить эту информацию и помощь на своем языке бесплатно. Членам профсоюза следует звонить по номеру телефону, указанному на обратной стороне их удостоверения личности. Все остальные могут звонить по номеру 855-258-6518 и дождаться диалога, пока не появится предложение нажать 0. Когда агент ответит, назовите нужный вам язык, и вас соединят с переводчиком.

Fa'alogo (Samoan): O lenei fa'aaliga o lo'o iai fa'amatalaga i vaega e kava e lau inisiua. E ono aofia ai aso taua ma atonu e te manaʻomia ai le faia o se gaioiga i nisi taimi faʻagata. E iai lau aia tatau e maua ai nei fa'amatalaga ma fesoasoani i lau gagana e aunoa ma se totogi. E tatau i sui auai ona vili le numera o le telefoni i tua o le latou pepa faamaonia. O isi uma e mafai ona vala'au i le 855-258-6518 ma fa'atali i le talanoaga se'ia fa'atonuina e oomi le 0. A tali mai se so'o upu, fa'ailoa atu le gagana e te mana'omia ona fa'afeso'ota'i lea o oe i se tagata fa'aliliu.

Pažnja (Serbian): Ovo obaveštenje sadrži informacije o vašem osiguranju. Može sadržati ključne datume i možda ćete morati da preduzmete akciju do određenih rokova. Imate prava da dobijete ove informacije i pomoć na vašem jeziku besplatno. Trebalo bi da članovi nazovu telefonski broj na poleđini svoje članske legitimacije. Svi ostali mogu pozvati 855-258-6518 i sačekati automat dok ne dobiju obaveštenje da pritisnu taster "0". Kada se agent javi, navedite jezik koji vam je potreban i bićete povezani s prevodiocem

Atención (Spanish): Este aviso contiene información sobre su cobertura de seguro. Puede contener fechas clave y es posible que deba tomar medidas antes de determinadas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin coste alguno. Los afiliados deben llamar al número de teléfono que figura en el reverso de su tarjeta de identificación del afiliado. Todos los demás pueden llamar al 855-258-6518 y esperar el diálogo hasta que se les solicite presionar 0. Cuando un agente responda, indique el idioma que necesita y se conectará con un intérprete.

Atensyon (Tagalog): Ang abisong ito ay naglalaman ng impormasyon tungkol sa saklaw ng iyong insurance. Maaaring naglalaman ito ng mga mahahalagang petsa at maaaring kailanganin mong kumilos ayon sa ilang partikular na mga deadline. May karapatan kang makuha ang impormasyong ito at tulong sa iyong wika nang walang bayad. Ang mga miyembro ay dapat tumawag sa numero ng telepono sa likod ng kanilang member identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa masabihan na pindutin ang 0. Kapag sumagot ang isang ahente, sabihin ang wikang kailangan mo at ikaw ay ikokonek sa isang tagapagsalin.

توجہ (Urdu): اس نوٹس میں آپ کی انشورنس کوریج کے بارے میں معلومات شامل ہیں۔ اس میں کلیدی تاریخیں شامل ہو سکتی ہیں اور آپ کو کچھ آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑ سکتی ہے۔ آپ کو یہ معلومات اور مدد اپنی زبان میں، بغیر کسی قیمت کے حاصل کرنے کا حق ہے۔ ممبران کو اپنے رکنیتی کارڈ کی پشت پر دئے گئے فون نمبر پر کال کرنی چاہیے۔ باقی تمام لوگ *855-258-6518* پر کال کر سکتے ہیں اور 0 دبانے کا اشارہ ملنے تک ڈائیلاگ پر انتظار کرنا چاہئیے۔ جب کوئی ایجنٹ جواب دیتا ہے تو اپنی مطلوبہ زبان بتائیں اور آپ کا رابطہ ایک مترجم سے کر دیا جائے گا۔

Lưu ý (Vietnamese): Thông báo này có chứa thông tin về phạm vi bảo hiểm của bạn. Nó có thể chứa các ngày quan trọng và bạn có thể cần phải hành động theo thời hạn nhất định. Bạn có quyền nhận thông tin và hỗ trợ này bằng ngôn ngữ của mình mà không mất phí. Các thành viên nên gọi đến số điện thoại ở mặt sau thẻ thành viên của mình. Những người khác có thể gọi đến số 855-258-6518 và chờ qua hội thoại cho đến khi được nhắc nhấn số 0. Khi có nhân viên trả lời, hãy nêu ngôn ngữ bạn cần và bạn sẽ được kết nối với phiên dịch viên.