Health Reimbursement Arrangement (HRA) Plan Design Guide

CareFirst BlueFund

Please complete this form and return to Further℠, CareFirst's HRA administrator, at least three weeks before your effective date to ensure proper administration of your plan. If you have any questions, please call BlueFund Customer Service at 866-758-6119. Send your completed form by secure email to **carefirstsales@hellofurther.com** or mail it to Further, c/o CareFirst, P.O. Box 14836, Lexington, KY 40511.

All fields are required unless otherwise noted. Incomplete forms will delay your plan setup.

1. EMPLOYER INFORMATION

Employer's name _____

Employer's tax ID number (required) _____

Type of corporation ○ S Corporation ○ C Corporation ○ Partnership ○ Sole Proprietor
○ Political Subdivision/Church ○ LLC ○ Non-Profit ○ Other _____

Number of employees eligible for the plan _____

Signing Authority

The person listed below is responsible for signing and approving the plan design guide and does not receive any marketing or operational communications from Further unless they are also the group administrator and the section below is left blank.

Name _____ Title _____

Phone number _____ Email address _____

Group Administrator (if different than above)

The person listed below has access to all plan information when contacting Further and will automatically be granted full access to the online BlueFund account.

Main contact name _____ Title _____

Phone number _____ Email address _____

Additional Contact Person (optional)

This person has access to the plan information indicated below when contacting Further. This person's online access is granted by the group administrator within the CareFirst employer portal.

Additional contact name _____ Title _____

Phone number _____ Email address _____

This person has access to the following information when contacting Further:

○ All plan data ○ Claim billing

To grant access to additional users or to add more contacts, log in to employer.carefirst.com. From the *Finance* tab, select *BlueFund* to access your account.

2. CAREFIRST INFORMATION

CareFirst account executive

Name _____

Phone number _____

Email address _____

CareFirst account manager

Name _____

Phone number _____

Email address _____

Further is an independent provider of administrative services for CareFirst BlueCross BlueShield consumer-directed health care plans. HealthEquity, Inc., the owner of the Further business, is an IRS-approved, non-bank trustee providing HSA custodial services on behalf of CareFirst BlueCross BlueShield to its members. HealthEquity Inc., on its own or through the Further business, does not sell BlueCross or BlueShield products.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which 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.

3. AGENCY/BROKERAGE INFORMATION

Name of agency/brokerage *(if applicable)* _____

Agency/brokerage address _____

Agency/brokerage tax ID _____

Agent/broker's name *(if applicable)* _____ Email address _____

Agent/broker code (NPN) _____ Agent/broker phone _____

4. TRANSFER OF ADMINISTRATION

Is Further replacing administrative services from another HRA administrator? ◯ Yes ◯ No

If yes, please complete the BlueFund HRA Transfer Addendum and submit with this plan design guide.

5. HEALTH PLAN ADMINISTRATIVE INFORMATION

Effective date _____

Are health plan accumulations per calendar year or plan year? ◯ Calendar year ◯ Plan year

Is your plan fully insured or self-insured? ◯ Fully insured ◯ Self-insured

6. ADMINISTRATIVE DEFINITIONS & NOTES

- **Medical crossover/autopay:** CareFirst will send eligible claim expenses to Further electronically to be processed and reimbursed according to the employee's available balance. Eligible expenses that would not be on a claims file (e.g., compliant over-the-counter medications), will require the employee to submit a request for reimbursement.

  Please note: Autopay is not appropriate for individuals who have secondary health coverage. Those employees should be directed to turn off this feature in their spending account profile at **carefirst.com/myaccount** and submit manual reimbursement requests instead.

  Members with autopay do not receive debit cards.

- **Pay the provider:** This feature allows an employee to have their medical claim reimbursement sent directly to their in-network provider, instead of to their home address or direct deposited into their bank account.
  - Providers are not paid at the time of service.
  - Network providers may request a copay or coinsurance amount from a member if they haven't yet met their health plan deductible. Your employees would be responsible for working with their provider directly to be reimbursed once Further has sent payment to the provider. If a provider tries to collect a deposit amount that isn't copay or coinsurance, this should be reported to CareFirst immediately.
  - **Copays and prescription claim amounts** are always paid to the employee and never to the provider, as it is assumed that the employee paid for this expense at the time of service.
  - Enrolled employees can choose to turn off the pay the provider option in their online profile.

  Pay the provider is not available with the debit card option.

  For additional assistance in understanding your options with medical crossover/autopay and pay the provider, please see the HRA Employer Guide available on the BlueFund CDH resources page at employer.carefirst.com.

- **Locations:** To request multiple Further locations, please complete and attach a **Location Addendum**. Locations must be the same across all products administered by Further. To request different ACH accounts by location, please complete the **Group ACH Authorization Agreement Form**.

- **Ineligible Employees:** You may have shareholders or highly compensated employees who aren't eligible to participate in an HRA. Please submit the **HRA Ineligible Employee Form** along with the plan design guide.

7. HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OPTIONS

How many different HRA plans will be offered to your employees? (select one)

○ One ○ Two ○ Other _____

If you would like to select more than one HRA, be sure to complete Sections 7–10 for each HRA attached to a different health plan. Include the specific health plan name that is associated with each HRA plan design.

Plan Year

Is the HRA funded per calendar year or plan year?

○ Calendar year start date: _____ *(calendar year end date is always the last day of the calendar year)*

○ Plan year start date: _____ End date: _____

Health Plan Name _____

Choose one of the two following HRA options:

○ **OPTION #1—EMPLOYER PAYS FIRST HRA**

With this option, you fund the HRA as expenses are reimbursed up to the preset amount you choose. The HRA pays until the funds are depleted. After that, the employee is responsible for out-of-pocket health care expenses.

Indicate the annual funding amount for the Employer Pays First HRA:

Member (single) = $_____ *(required)* Member + children = $_____

Member + child = $_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse = $_____

Eligible expenses, claims and reimbursement options—choose only ONE of the five following options:

○ **1. All medical expenses** (incl. deductible/copay/coinsurance)
- ○ Debit card with employee option for medical crossover/autopay (default)
- ○ Medical crossover/autopay only—select one of the following:
  - ○ Enroll all employees in pay the provider automatically (Members can opt-out)
  - ○ Do not offer pay the provider

○ **2. All health care eligible expenses** (incl. medical/drug/dental/vision/otc)
- ○ Debit card with employee option for medical crossover/autopay (default)
- ○ Medical crossover/autopay only—select one of the following:
  - ○ Enroll all employees in pay the provider automatically (Members can opt-out)
  - ○ Do not offer pay the provider

○ **3. All medical and drug expenses**
- ○ Debit card with employee option for medical crossover/autopay (default)
- ○ Medical crossover/autopay only—select one of the following:
  - ○ Enroll all employees in pay the provider automatically. (Members can opt-out)
  - ○ Do not offer pay the provider

○ **4. Medical deductible only**

Medical crossover/autopay only—select one of the following:
- ○ Enroll all employees in pay the provider automatically. (Members can opt-out)
- ○ Do not offer pay the provider

○ **5. Drug expenses only**

Debit card with employee option for medical crossover/autopay (default)

7. HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OPTIONS (continued)

○ **OPTION #2—EMPLOYEE PAYS FIRST HRA**

With this option, the employee pays out of pocket until the preset amount you choose below has been paid. When this amount has been reached, the HRA pays until depleted. You fund the HRA up to predetermined amount set by you. After that, the employee is responsible for out-of-pocket health care expenses.

Indicate your **health plan deductible amounts** by coverage tier:

Member (single) = $_____ *(required)* Member + children = $_____

Member + child = $_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse = $_____

Indicate the **employee responsibility amount***: *(This is the amount that the employee will pay out of pocket prior to reimbursement from the employer funding amount.)*

Member (single) = $_____ *(required)* Member + children = $_____

Member + child = $_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse = $_____

Indicate the **employer funding amount***: *(This is the amount that the employer will pay for each coverage tier after the employee has satisfied their employee responsibility amount.)*

Member (single) = $_____ *(required)* Member + children = $_____

Member + child = $_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse = $_____

Eligible expenses, claims and reimbursement options—choose only ONE of the four following expense options:

○ **1. All medical expenses** (incl. deductible/copay/coinsurance)
Medical crossover/autopay only
○ Enroll all employees in pay the provider automatically (Members can opt-out) ○ Do not offer pay the provider

○ **2. All health care eligible expenses** (incl. medical/drug/dental/vision/otc)
Medical crossover/autopay only
○ Enroll all employees in pay the provider automatically (Members can opt-out) ○ Do not offer pay the provider

○ **3. All medical and drug expenses**
Medical crossover/autopay only
○ Enroll all employees in pay the provider automatically (Members can opt-out) ○ Do not offer pay the provider

○ **4. Medical deductible only**
Medical crossover/autopay only
○ Enroll all employees in pay the provider automatically (Members can opt-out) ○ Do not offer pay the provider

8. HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ADMINISTRATIVE REQUIREMENTS

Mid-year enrollees/contract changes

Indicate how mid-year enrollees and contract changes will be administered: **(select one)**

- ◯ HRA funding is 100% regardless of date of enrollment/contract change.
- ◯ HRA funding is prorated in monthly increments back to the first of the month of the date of enrollment/contract change.

Rollover

Select one option below for unused balances at the end of the plan year. If an Employee Pays First HRA is selected, rollover dollars can only be used AFTER the annual employee responsibility amount has been met.

- ◯ Entire balance rolls over to subsequent plan year
- ◯ No balance rolls over
- ◯ A dollar limit on the amount that can roll over to the subsequent plan year. Rollover amount cannot be the same as funding amount. Indicate limits below:

Member (single) =$_____ *(required)* Member + children = $_____

Member + child =$_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse =$_____

Cap on HRA balance

Is there a cap on the overall balance (including rollover) that can accumulate in the account? ◯ Yes ◯ No

If yes, the recommended cap is the annual deductible amount or total annual out-of-pocket amount. Please indicate amounts below:

Member (single) =$_____ *(required)* Member + children = $_____

Member + child =$_____ Member + spouse + child(ren) (family) = $_____ *(required)*

Member + spouse =$_____

Runout period

Members have _____ months after the end of the plan year to submit claims incurred during that plan year.
(The standard runout period is 3 months.)

The runout period noted above begins at termination date for terminated employees.

Terminations

Indicate what happens to the HRA balance when a member terminates and does not elect COBRA. **NOTE:** HRAs stay with terminated members if COBRA is elected ***(mandatory)***. **Select one:**

- ◯ Account balance returns to employer if terminated member or eligible dependent does not elect COBRA. ***(Default)***
- ◯ Account balance remains with terminated member or eligible dependent to spend-down until funds are depleted. If spend-down is selected, eligible expenses for terminated members remain the same as for active members. Spend-down is subject to any applicable rollover and runout period provisions and fees. *(Not available for Employee Pays First HRAs)*

Copay amounts (not required if election is medical crossover/autopay only)

The copay amounts provided below will allow these amounts to auto-substantiate when the debit card is used. Documentation will not be required for reimbursements.

Please indicate the health plan copay amounts below or attach a separate spreadsheet indicating the copay amounts.

Medical _____ Vision _____ Drug _____

9. CLAIM REIMBURSEMENT PROCESSING—*Completion of this section is mandatory*

You will receive an automated email notification with the claim reimbursement totals. Log in to **employer.carefirst.com** to view and print your complete invoice detail.

Automated Clearinghouse (ACH) information

I hereby authorize Further to charge our bank account through ACH for **claim reimbursements**. The following bank account information is provided to Further for initiation of this procedure.

Bank name _____

Bank ABA number _____ Account type: ◯ Checking ◯ Savings
(*The ABA number is the nine-digit number located in the lower left corner of your check.*)

Bank account number _____

10. SIGNATURE

I agree that necessary information concerning current and future members and/or their dependents who participate in this plan, and members whose participation is to be changed or discontinued, will be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Please note: A health savings account (HSA) plan paired with a health reimbursement arrangement (HRA) poses possible tax code concerns. An employee who enrolls in the HSA health plan and participates in the HRA may not be eligible to open or contribute to their own HSA. Employees must be advised.

This form requires an original signature or a certified electronic signature.

Signature _____ Date _____

Printed name _____ Title _____

11. FOR OFFICE USE ONLY

Further group number _____ Sales executive _____

Market segment _____ Further account manager _____

CareFirst account manager _____ Further client manager _____

Broker partner _____ Further enrollment specialist _____

Broker account manager _____

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.