Catastrophic Health Expense Program Claim Form

(Grandfathered)

CareFirst

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):	Date of first symptom(s):
A.	A. / /
B.	B. / /
C.	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:

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. which is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ℠ Registered trademark of CareFirst of Maryland, Inc.

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**

Dr. J. R. Barnes (1)
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 (1)
888 Market St
New Town, MD 11111
(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 (3) 111 Park Place New Town, MD, 11112	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 (9)	Quantity	Unit Price (15)	Total Charges	Diagnosis (Principal/Admitting)
6/30/2018	Room 10 I	202	1	$1,972.00	$1,972.00	786.59
7/1/2018	Room 10 I	202	1	$1,972.00	$1,972.00	(12)
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	

(13)

Total Charges: $6,012.06

Attending Physician: Dr. J.R. Barnes
NPI: 1122334455

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

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 (1)
200 Market St.
New Town, MD 111111
(443) 555-1234

Pharmacist: Dr. John A. Price (8)

Patient: Rosa L Jones (2)

(3) Date	(4) Drug name, dosage and quantity	(5) NDC	(6) Charge	(7) Prescribing doctor name, tax ID and NPI
8/8/18	Amoxicillin (10) 875 mg	1912-2116-08	$2.75	Dr. George Smith TaxID:111111111 NPI: 2222222222
8/8/18	Synthroid (90) 0.1 mg	1912-2116-08	$14.95	Dr. J. R. Barnes TaxID:555111333 NPI: 1122334455
10/16/18	Amoxicillin (10) 875 mg	3579-5512-58	$1.40	Dr. George Smith TaxID:111111111 NPI: 2222222222

Total: $19.10

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

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.