# 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 _____

## 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 8/5/19)

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<br>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**.

## 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። ይኽን 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।

*Bàsɔ́ɔ̀-wùqù (Bassa)* Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fûà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɋé wé jéɛ́ ɓě ɓɛ́ m̀ ké ɋɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɋé nì ɓíɖí-wùqù mú ɓɛ́ m̀ ké se wíɖí ɋò péɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɋá fǔùn-nɔ̀ɓà nìà ɋé waà I.D. káàɔ̀ ɋeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɋá 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 hwè. Ɔ jǔ ké nyɔ ɋò dyi m̀ gɔ̃ jǔǐn, po wuɋu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɋò mu ɓó nììn ɓé ɔ ké nì wuɋuɔ̀ 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' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'įįh. Bee ná ahóót'i' díí bee ił hane' dóó nikáádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Ákáa'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.