CareFirst

Benefits Enrollment & Reference Guide 2023

Effective July 1, 2023–June 30, 2024
Active and Under 65 Retirees

HARFORD COUNTY GOVERNMENTAL ENTITIES

Contents

The purpose of this Enrollment and Reference Guide is to provide information about your benefits options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to your Employee Benefit Guide or Certificate of Coverage for information about the plans.

Every effort has been made to ensure that the information in this Guide is accurate; however, the provisions of the actual contracts for each plan will govern in the event of any discrepancy.

Benefits and Eligibility

Eligibility

Dependents*

Eligible family members include your:

- Legal spouse
- Dependent children until the end of the month in which they reach age 26
- Unmarried dependent children over the age limit if:
  - They are dependent on you for primary financial support and maintenance due to a physical or mental disability,
  - They are incapable of self-support, and
  - The disability existed before reaching age 26 or while covered under the plan.

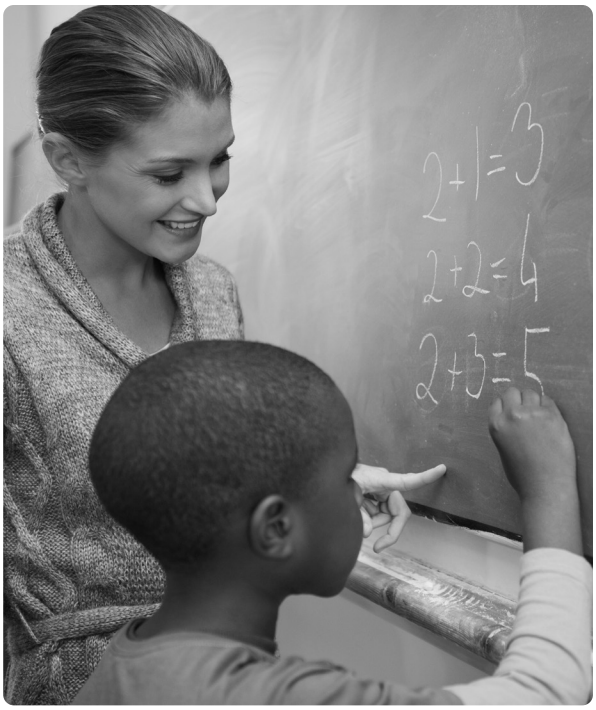
Eligible children include your:

- Natural children
- Stepchildren
- Legally adopted children
- Foster children
- A child for whom you have legal guardianship including grandchildren
- Child for whom the court has issued a QMSCO (Qualified Medical Child Support Order)

Ineligibility

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse (ex-spouse, fiancé, common-law spouse, etc.)
- Dependents no longer covered by a court order
- Live-in partners
- Children of live-in partners
- Stepchildren following divorce from natural parent
- Parents of employees



* **You must submit life event changes within 30 days of event and verification of eligibility for all dependents on your account within 30 days of enrollment.**

Dependent Eligibility Documentation Requirements		
Relationship to Employee	**Eligibility Definition**	**Documentation for Verification of Relationship**

Spouse	A person to whom you are legally married	▪ **Copy of last year's Federal Tax Return** with the financial information crossed out. The tax form should be signed or submitted with proof of electronic filing **OR**
		▪ **Proof of Current Joint Owership.** Document must be dated within the last six months and include the employee's name, spouse's name and current address. Acceptable documents include:
		  ▪ Mortgage statement or renntal/lease agreement (financial information crossed out)
		  ▪ Property tax bill (financial information crossed out)
		  ▪ Joint checking or savings account statement (financial information crossed out)

Dependent Child(ren)	Dependent children until the end of the month in which they reach age 26	▪ **Natural Child**—Provide 1 of the following:
		  ▪ Copy of birth certificate showing employee's name **OR**
		  ▪ Hospital verification of birth (must include child's name, date of birth and parents' names) **OR**
		  ▪ Certificate of birth
		▪ **Step Child**—Provide 1 of the above showing employee's spouse name; and a copy of marriage certificate showing the employee and parent's name
		▪ **Legal Guardian, Adoption, Grandchild(ren), or Foster Child(ren)**—Copy of Final Court Ordered Custody with presiding judge's signature and seal, or Adoption Final Decree with presiding judge's signature and seal.
		▪ **Child for whom the court has issued a QMSCO**—A copy of the Qualified Medical Child Support Order

Disabled Dependents	Unmarried dependent children over the age limit if: 1. They are dependent on you for primary financial support and maintenance due to a physical or mental disability, 2. They are incapable of self-support, and 3. The disability existed before reaching age 26 or while covered under the plan.	▪ Copy of Social Security disability award (if a disability ruling by Social Security is pending, include a current copy of the application for disability) **AND** ▪ Federal Tax Return for year just filed **AND** ▪ Completed Disability Form (Request from Benefits Office)

Patient-Centered Medical Home

Supporting the relationship between you and your doctor

Whether you're trying to get healthy or stay healthy, you need the best care. That's why CareFirst[1] created the Patient-Centered Medical Home (PCMH) program to focus on the relationship between you and your primary care provider (PCP).

The program is designed to provide your PCP with a more complete view of your health needs. Your PCP will be able to use information to better manage and coordinate your care with all your health care providers including specialists, labs, pharmacies and others to ensure you get access to, and receive the most appropriate care in the most affordable settings.

Extra care for certain health conditions

If you have certain health conditions, your PCMH PCP will partner with a care coordinator, a registered nurse, to:

- Create a care plan based on your health needs with specific follow up activities
- Review your medications and possible drug interactions
- Check in with you to make sure you're following your treatment plan
- Assist you in obtaining services and equipment necessary to manage your health condition(s)

A PCP is important to your health

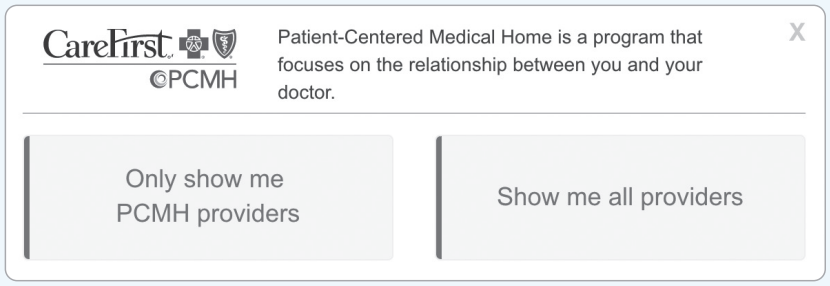
By visiting your PCP for routine visits, you build a relationship, and your PCP will get to know you and your medical history.

If you have an urgent health issue, having a PCP who knows your history often makes it easier and faster to get the care you need.

Even if you are young and healthy, or don't visit the doctor often, choosing a PCP is key to maintaining good health.

PCPs play a huge role in keeping you healthy for the long run. If you don't already have a relationship with a doctor, you can begin researching one today!

- To find a PCMH PCP, look for the PCMH logo when searching for primary care providers in our Provider Directory or log in to *My Account* and click *Select/Change PCP* under *Quick Links.*



[1] All references to CareFirst refer to CareFirst BlueCross BlueShield and CareFirst, BlueChoice, Inc., collectively.

CST1310-1P (9/17)

Triple Option Open Access

Available only to out-of-state residents

Triple Option Open Access offers you the freedom to visit any provider you wish. You have the flexibility to choose from both in- and out-of-network providers with your out-of-pocket costs determined by your choice. There is no need to choose a primary care provider (PCP) or to obtain a referral before visiting a specialist.

Benefits of the Triple Option Open Access Plan

- The ability to visit providers from either our BlueChoice Network, National PPO Network or out-of-area providers
- No PCP referral required to see a specialist
- Receive coverage for preventive health care services at no cost
- Take your health care benefits with you—across the country and around the world

How your plan works

With the Triple Option Open Access plan, you can visit any provider of your choosing. Your out-of-pocket costs are determined by who you decide to see.

In-network benefits provide a higher level of coverage, meaning you have lower out-of-pocket costs. Out-of-network benefits provide a lower level of coverage in exchange for the freedom to seek care from any provider you choose.

Your in- and out-of-network benefits are organized into three levels of coverage.

Level 1: For your lowest and most predictable in-network out-of-pocket costs, choose a BlueChoice provider. You can visit any of the 37,000 BlueChoice providers within Maryland, Washington, D.C. and Northern Virginia. Visit our online provider directory at **carefirst.com/doctor** to locate in-network providers.

Remember, you have direct access to CareFirst BlueChoice specialists without needing to obtain a referral from your PCP.

Level 2: To receive level 2 in-network benefits, visit a provider who participates in the national BlueCard® PPO network of over 600,000 doctors and 61,000 hospitals.

To identify an in-network CareFirst PPO provider, visit **carefirst.com/doctor**. To find a national BlueCard provider, visit the national provider directory at **provider.bcbs.com**.

Level 3: This level of coverage is out-of-network and offers you the most flexibility. In exchange for a lower level of coverage, you have the freedom to seek care from any provider you choose.

If you receive services from a provider who does not participate in any of the networks listed above, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

In general, out-of-network providers do not have an agreement with CareFirst to accept the allowed benefit as payment in full for their services. Therefore, if you receive services from a non-participating provider, you may be balance billed based on the provider's actual charge.

Certain services under this level of coverage require you to meet a deductible. Check your benefits enrollment guide for details. When applicable, you are responsible for the entire cost of your medical care up to the amount of your deductible. Once your deductible is satisfied, your coverage will become available. Depending on the service, you may have to pay a copay or coinsurance when you receive care.

Hospital authorization

In-network providers will obtain any necessary admission authorizations for in-area (Maryland, Washington, D.C. and Northern VA). You will be responsible for obtaining authorization for services provided by out-of-network and out-of-area admissions. Call toll-free 888-PRE-AUTH (773-2884).

Inpatient Hospital Stay Claim					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$14,800	$8,160	$7,344	$816	10% AB
PPO/Level 2	$14,800	$9,180	$8,262	$918	10% AB
Participating*/Level 3	$14,800	$10,200	$6,640	$3,560	$500 deductible then 30% AB
Non-participating*/Level 3	$14,800	$10,200	$6,640	$8,160	$500 deductible then 30% AB ($3,560 + balance to charge $4,600)
Primary Care Provider Office Visit					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$150	$64	$57.60	$6.40	10% AB
PPO/Level 2	$150	$72	$64.80	$7.20	10% AB
Participating*/Level 3	$150	$80	$0	$80	Deductible applied
Non-participating*/Level 3	$150	$80	$0	$150	$80 deductible plus balance to charge $70
Maternity Provider Delivery Charge					
Provider Status/Benefit Level	**Amount Charged**	**Allowed Benefit**	**CareFirst BlueCross BlueShield Pays**	**Member Pays**	
BlueChoice/Level 1	$5,864	$3,616	$3,254.40 (90% AB)	$361.60	10% AB
PPO/Level 2	$5,864	$4,068	$3,661.20 (90% AB)	$406.80	10% AB
Participating*/Level 3	$5,864	$4,520	$3,164	$1,356	Deductible was already met 30% AB
Non-participating*/Level 3	$5,864	$4,520	$3,164	$2,700	Deductible was met 30% AB $1,356 + difference to charge $1,344

BlueCard & Blue Cross Blue Shield Global® Core

Wherever you go, your health care coverage goes with you

With your Blue Cross and Blue Shield member ID card, you have access to doctors and hospitals almost anywhere. BlueCard gives you the peace of mind that you'll always have the care you need when you're away from home, from coast to coast. And with Blue Cross Blue Shield Global® Core (BCBS Global® Core) you have access to care outside of the U.S.

As always, go directly to the nearest hospital in an emergency.

Your membership gives you a world of choices. More than 93% of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care here in the United States or abroad, you'll have access to health care in more than 190 countries.

When you're outside of the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C., and Northern Virginia), you'll have access to the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals in that area. You shouldn't have to pay any amount above these negotiated rates. Also, you shouldn't have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductibles, copayments, and coinsurance) that you'd pay anyway.

Within the U.S.

1. Always carry your current member ID card for easy reference and access to service.
2. To find names and addresses of nearby doctors and hospitals, visit the National Doctor and Hospital Finder at **www.bcbs.com**, or call BlueCard Access at 800-810-BLUE (2583).
3. Call the Customer Service number on the back of your member ID card to verify benefits or find out if pre-certification or prior authorization is required.
4. When you arrive at the participating doctor's office or hospital, simply present your ID card.
5. After you receive care, you shouldn't have to complete any claim forms or have to pay up front for medical services other than the usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Around the world

Like your passport, you should always carry your ID card when you travel or live outside the U.S. The Blue Cross Blue Shield Global® Core program (BCBS Global® Core) provides medical assistance services and access to doctors, hospitals and other health care professionals around the world. Follow the same process as if you were in the U.S. with the following exceptions:

- At hospitals in the BCBS Global Core Network, you shouldn't have to pay up front for inpatient care, in most cases. You're responsible for the usual out-of-pocket expenses. And, the hospital should submit your claim.
- At hospitals outside the BCBS Global Core Network, you pay the doctor or hospital for inpatient care, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BCBS Global Core Service Center. The claim form is available online at **bcbs.globalcore.com**.
- To find a BlueCard provider outside of the U.S. visit **bcbs.com**, select *Find a Doctor or Hospital.*

Members of Maryland Small Group Reform (MSGR) groups have access to emergency coverage only outside of the U.S.

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

Visit **bcbs.com** to find providers within the U.S. and around the world.

BRC6290-9P (2/20)

BlueChoice Opt-Out Plus Open Access

A plan with predictable costs and the freedom to choose

BlueChoice Opt-Out Plus Open Access offers in- and out-of-network coverage to help control your out-of-pocket costs and there's no referral to see a specialist. We also offer online tools and resources at **carefirst.com** that give you the flexibility to manage your health and wellness goals wherever you are.

Take advantage of your benefits

- $0 cost for comprehensive preventive healthcare visits.
- Choose any provider—no referrals needed.
- A network of almost 47,000 CareFirst BlueChoice providers (primary care providers (PCPs), nurse practitioners, specialists, hospitals, pharmacies, and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care, including a free 24-hour nurse advice line, video visits for physical and mental health, convenience care clinics and urgent care centers.
- If you need care outside the CareFirst BlueCross BlueShield (CareFirst) service area of Maryland, Washington, D.C. and Northern Virginia, you have access to the largest network across the country, with 96% of hospitals and 95% of physicians in-network.
- No balance billing when you visit a CareFirst BlueChoice or BlueCard® PPO provider.

Benefits at a glance

Preventive care and sick office visits

You are covered for all preventive care as well as sick office visits.

Large provider network

You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services

Your coverage includes services from specialists without a referral. Specialists are doctors or nurses who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage

Your plan covers prescription drugs.

Hospital services

You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all inpatient hospital services and may need to provide prior authorization for some outpatient hospital services such as rehabilitative services, chemotherapy and infusion services.

BlueChoice Opt-Out Plus Open Access

Labs, X-rays or specialty imaging
Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

Well-child visits
All well-child visits and immunizations are covered.

Maternity and pregnancy care
You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder
Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

In-network benefits provide a higher level of coverage. This means you have lower out-of-pocket costs when you visit a participating CareFirst BlueChoice provider. However, the choice is entirely yours. That's the advantage of this plan.

Out-of-network benefits are also available. If you receive care outside of the BlueChoice network, you'll incur lower costs by using a participating national BlueCard PPO provider. Your benefits will be paid at the out-of-network level, but you will be protected from balance billing. To find a national participating provider, visit **carefirst.com/doctor**.

You still have the option to opt-out of this network and see a non-participating provider, but will be subject to higher out-of-pocket expenses and could be balanced billed.

If you receive services from a provider outside of the BlueChoice or national BlueCard PPO networks, you may have to:

- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

Hospital authorization

CareFirst BlueChoice providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by out-of-network providers and out-of-area admissions. Call toll-free at 866-PREAUTH (773-2884).

Prior authorization is not required for emergency admissions or maternity admissions.

In-network

In-network you pay: **$**
BlueChoice network

Out-of-network

Out-of-network you pay: **$$**
BlueCard PPO network

Non-participating providers you pay: **$$$**
(Balance billing may apply)

Your benefits

Step 1: Select a PCP

Establishing a relationship with one doctor is the best way to receive consistent, quality healthcare. When you enroll in a BlueChoice HMO plan, you select a PCP—either a physician or nurse practitioner—to manage your primary medical care. Make sure you select a PCP for yourself and each of your covered family members. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in family practice, general practice, pediatrics or internal medicine.

To ensure that you receive the highest level of benefits and pay the lowest out-of-pocket costs for all services, see your PCP for preventive and routine care.

Step 2: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 3: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met. However, the level of those benefits will depend on whether you see in-network or out-of-network providers. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

You will have a different deductible amount for in-network versus out-of-network benefits and the in- and out-of-network medical deductibles contribute toward one another. For example, when you see in-network providers, your expenses will count toward both your in-network deductible and out-of-network deductible.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

Just like your deductible, there are different in-network and out-of-network amounts and the in- and out-of-network out-of-pocket maximums contribute toward one another.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

Labs, X-rays or specialty imaging

If you access laboratory services inside the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia) you must use LabCorp as your lab test facility for in-network benefits. Services performed by any other provider, while inside the CareFirst service area, will be considered out-of-network. Also, any lab work performed in an outpatient hospital setting will require prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. For locations near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

If you access laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO facility and receive out-of-network benefits. To find laboratory service providers outside of the CareFirst service area, visit our *Find a Provider* tool (**carefirst.com/doctor**) and search by *Labs*.

If you need X-rays or other specialty imaging services when inside the CareFirst service area, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology. If you need X-rays or other specialty imaging services when outside the CareFirst service area, you may use any participating BlueCard PPO facility and receive out-of-network benefits.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

Out-of-area coverage

You have the freedom to take your healthcare benefits with you. BlueCard PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive healthcare benefits while traveling outside of the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia). The BlueCard program includes the broadest coverage and largest number of participating providers, with more than 500,000 unique providers and 8,896 hospitals in the United States.

For urgent and emergency services received outside of the CareFirst service area, you will receive in-network benefits. All other services received outside of the service area will be at the out-of-network level.

Away From Home Care

In addition, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away From Home Care®.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart.

For more information on Away From Home Care, please call Member Services at the phone number listed on the back of your ID card.

Global Coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you receive:

- Access to a worldwide network of traditional inpatient, outpatient, and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, Global Core connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

BALANCE BILLING: Billing a member for the difference between the allowed charge and the actual charge.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network.

PRIMARY CARE PROVIDER (PCP): The doctor or medical professional you go to for primary care and who coordinates or arranges other services you need.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association.

FOL5089-1P (7/21) ■ 51+

BlueVision Summary of Benefits

We're not an eyewear plan. We're an eye care plan.

12-month benefit period

In-Network	You Pay
EYE EXAMINATIONS[1]	
Routine Eye Examination with dilation (per benefit period)	$10
FRAMES[1,2]	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 90% of the amount over $70
SPECTACLE LENSES2	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
LENS OPTIONS[2,3] (add to spectacle lens prices above)	
Standard Progressive Lenses	$75
Premium Progressive Lenses (Varilux®, etc.)	$125
Ultra Progressive Lenses (Digital)	$140
Polarized Lenses	$75
High Index Lenses	$55
Glass Lenses	$18
Polycarbonate Lenses	$30

In-Network	You Pay
LENS OPTIONS[1,2] (add to spectacle lens prices above)	
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Lenses	$35
Scratch-Resistant Coating	$20
Standard Anti-Reflective (AR) Coating	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
CONTACT LENSES[1]	
Contact Lens Evaluation and Fitting	85% of retail price
Conventional	80% of retail price
Disposable/Planned Replacement	90% of retail price
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices
LASER VISION CORRECTION[1]	
Up to 25% off allowed amount or 5% off any advertised special[3]	

[1] At certain retail locations, members receive comparable value through their everyday low price on examination, frame and contact lens purchase.

[2] CareFirst BlueChoice does not underwrite lenses, frames and contact lenses in this program. This portion of the Plan is not an insurance product. As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

[3] Special lens designs, materials, powers and frames may require additional cost.

[4] Some providers have flat fees that are equivalent to these discounts.

Exclusions
The following services are excluded from coverage:

1. Diagnostic services, except as listed in What's Covered under the Evidence of Coverage.
2. Medical care or surgery. Covered services related to medical conditions of the eye may be covered under the Evidence of Coverage.
3. Prescription drugs obtained and self-administered by the mem
4. Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered under the Evidence of Coverage or a rider or endorsement purchased by your Group and attached to the Evidence of Coverage.
5. Services or supplies not specifically approved by the Vision Care Designee where required in What's Covered under the Evidence of Coverage.
6. Orthoptics, vision training and low vision aids.
7. Glasses, sunglasses or contact lenses.
8. Vision Care services for cosmetic use.
9. Services obtained from Non-Contracting Providers.

For BlueChoice Opt-Out Plus members, Vision Care benefits are not available under the Out-of-Network Evidence of Coverage.

Exclusions apply to the Routine Eye Examination portion of your vision coverage. Discounts on materials such as glasses and contacts may still apply.

Benefits issued under policy form numbers: MD/BC-OOP/VISION (R. 6/04) • DC/BC-OOP/VISION (R. 6/04) • VA/BC-OOP/VISION (R. 6/04)

BRC6420-1P (8/22) ■ 12 month/$10 copay ■ BlueVision ■ Option 3

BlueVision—a plan for healthy eyes, healthy lives

Professional vision services including routine eye examinations, eyeglasses and contact lenses offered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, through the Davis Vision, Inc., a national network of providers.

How the plan works?

How do I find a provider

To find a provider, go to **carefirst.com** and utilize the *Find a Provider* feature or call Davis Vision at **800-783-5602** for a list of network providers closest to you. Be sure to ask your provider if he or she participates with the Davis Vision network before you receive care.

How do I receive care from a network provider?

Simply call your provider and schedule an appointment. Identify yourself as a CareFirst BlueChoice member and provide the doctor with your identification number, as well as your date of birth. Then go to the provider to receive your service. There are no claim forms to file.

Can I get contacts and eyeglasses in the same benefit period?

With BlueVision, the benefit covers one pair of eyeglasses or a supply of contact lenses per benefit period at a discounted price[1].

Mail order replacement contact lenses

DavisVisionContacts.com offers members the flexibility to shop for replacement contact lenses online after benefits are spent. This website offers a wide array of contact lenses, easy, convenient purchasing online and quick shipping direct to your door.

Need more information?
Visit **carefirst.com** or call 800-783-5602.

[1] As of 4/1/14, some providers in Maryland and Virginia may no longer provide these discounts.

Away From Home Care®

Your HMO coverage goes with you

We've got you covered when you're away from home for 90 consecutive days or more. Whether you're out-of-town on extended business, traveling, or going to school out-of-state, you have access to routine and urgent care with our Away From Home Care program.

Coverage while you're away

You're covered when you see a provider of an affiliated Blue Cross Blue Shield HMO (Host HMO) outside of the CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia). If you receive care, then you're considered a member of that Host HMO receiving the benefits under that plan. So your copays may be different than when you're in the CareFirst BlueChoice service area. You'll be responsible for any copays under that plan.

Enrolling in Away From Home Care

To make sure you and your covered dependents have ongoing access to care:

- Call the Member Service phone number on your ID card and ask for the Away From Home Care Coordinator.
- The coordinator will let you know the name of the Host HMO in the area. **If there are no participating affiliated HMOs in the area, the program will not be available to you.**
- The coordinator will help you choose a primary care physician (PCP) and complete the application. Once completed, the coordinator will send you the application to sign and date.
- Once the application is returned, we will send it to your Host HMO.

Always remember to carry your ID card to access Away From Home Care.

- The Host HMO will send you a new, temporary ID card which will identify your PCP and information on how to access your benefits while using Away From Home Care.
- Simply call your Host HMO primary care physician for an appointment when you need care.

No paperwork or upfront costs

Once you are enrolled in the program and receive care, you don't have to complete claim forms, so there is no paperwork. And you're only responsible for out-of-pocket expenses such as copays, deductibles, coinsurance and the cost of non-covered services.

BRC6389-1P (8/17)

Prescription Drug Program

A total prescription for health

Prescription drugs are an integral part of high-quality health care. The prescription benefits your employer is offering give you an affordable and convenient way to make the best decisions when it comes to your prescriptions.

Your prescription benefits

As a CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) member, you'll have access to:

- A nationwide network of 66,000 participating pharmacies[1]
- Access to thousands of covered prescription drugs
- Mail Service Pharmacy, a convenient and fast option to refill your prescriptions through home delivery
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs

Keeping you informed

Together with our pharmacy benefit manager, CVS Caremark®[2], we keep you informed about your prescription drug coverage and provide you with periodic updates about your plan through targeted mailings and phone calls. Take the call and/or review your mailed notices to learn about lower-cost drug alternatives, possible safety concerns, drug tier changes and more.

Online tools and resources

To get the most from your prescription drug plan, you need to stay informed. Our easy-to-use, interactive tools and resources are available 24/7. Visit **carefirst.com/rxgroup** to see if a drug is covered, find a pharmacy, learn how drugs interact with each other and get more information about medications. You can access even more tools and resources once you're a member through *My Account* **(carefirst.com/myaccount)** by selecting *Drug and Pharmacy Resources* under *Coverage.*

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

[2] CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members.

3-Tier Non-Risk (ASO)

Understanding your formulary

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective. The prescription drugs found on the CareFirst Formulary (drug list) are divided into tiers. These tiers include zero-dollar cost share, generics, preferred brand and non-preferred brand drugs. Your cost share is determined by the tier the drug falls into.

Drug tier	Description
Tier 0: $0 Drugs	■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero dollar cost share.
Tier 1: Generic Drugs $	■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-Preferred Brand Drugs $$$	■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.

Note: If the cost of your drug is less than your copay or coinsurance, you only pay the cost of the drug. Once you meet your deductible (if applicable to your plan), you may pay a different copay or coinsurance for drugs depending on the drug tier. Some drugs may not be covered based on your plan. There is an exception process if you need an excluded drug to be covered for medical necessity reasons. Check your benefit summary or enrollment materials for specific plan information. Once you are a member, you can view specific cost-share information in *My Account.*

Preferred Drug List

CareFirst's Preferred Drug List includes generic and preferred brand drugs selected for their quality, effectiveness and safety by the CVS Caremark national Pharmacy and Therapeutics (P&T) committee. By using the Preferred Drug List, you can work with your doctor or pharmacist to make safe and cost-effective decisions to better manage your health care and out-of-pocket costs.

Non-preferred drugs aren't included on the Preferred Drug List; they are still covered but at the highest cost share. Also, some drugs on the Preferred Drug List may not be covered based on your plan. To see your formulary and Preferred Drug List, go to **carefirst.com/rxgroup**.

Prescription guidelines

Some medications are only intended to be used in limited quantities; others require that your doctor obtain prior authorization through CareFirst before they can be filled. These drug guidelines are indicated on the formulary found at **carefirst.com/rxgroup**.

- **Quantity limits** are placed on selected drugs for safety, quality or utilization reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. If your doctor decides that a different quantity of medication is right for you, your doctor can request prior authorization for coverage.
- **Prior authorization** is required before you fill prescriptions for certain drugs. Your doctor must obtain prior authorization before they can be filled. Without prior authorization approval, your drugs may not be covered.
- **Step therapy** ensures you receive a lower-cost drug option as the first step in treating certain health conditions. When similar drugs are available, step therapy guides your doctor to prescribe the lower-cost option first. You may then move up the cost levels until you find the drug that works best for you. Higher step drugs may require prior authorization by your doctor before they can be covered.

Two ways to fill

Retail pharmacies

With access to 66,000 pharmacies[1] across the country, you can visit **carefirst.com/rxgroup** and use our *Find a Pharmacy* tool to locate a convenient participating pharmacy. Be sure to take your prescription and member ID card with you when filling prescriptions.

Mail Service Pharmacy

Mail order is a convenient way to fill your prescriptions, especially for refilling drugs taken frequently. You can register three ways—online through *My Account*, by phone or by mail. Once you register, you'll be able to:

- Refill prescriptions online, by phone or by email
- Choose your delivery location
- Consult with pharmacists by phone 24/7
- Schedule automatic refills
- Receive email notification of order status
- Choose from multiple payment options

Ways to save

Here are some ways to help you save on your prescription drug costs.

- **Use generic drugs**—generic drugs can cost up to 80% less than their brand-name counterparts. Made with the same active ingredients as their brand-name counterparts, generics are also equivalent in dosage, safety, strength, quality, performance and intended use.
- **Use drugs on the Preferred Drug List**—the Preferred Drug List identifies generic and preferred brand drugs that may save you money.
- **Use the Drug Pricing Tool**—this tool allows you to compare the cost of a drug purchased at a pharmacy versus purchasing the same drug through mail order, as well as view generic drugs available at a lower cost.
- **Use mail order**—by using our Mail Service Pharmacy you get the added convenience of having your prescriptions delivered right to your home. Plus, if you pay a coinsurance for your maintenance drugs, the overall cost of the drug may be less expensive through mail order, reducing your out-of-pocket costs.

[1] If your employer has selected the RxChoice network, you will have access to 57,000 retail pharmacies.

Care management programs

We offer care management programs and tools designed to improve your health while lowering your overall health care costs.

Specialty Pharmacy Coordination Program

This program addresses the unique clinical needs of members taking high-cost specialty drugs for certain complex health conditions like multiple sclerosis, rheumatoid arthritis and hemophilia. Members receive enhanced one-on-one support with a registered nurse and dedicated clinical team who will coordinate care with your doctor.

The program provides:

- 24-hour pharmacist assistance
- Injection training coordination
- Educational materials for your specific condition
- Drug interaction monitoring and review
- A one-month supply of your specialty drugs mailed to your home or office, or available for pick up at any CVS retail pharmacy

Comprehensive Medication Review

When you are taking multiple drugs to treat a medical condition, it can be overwhelming. The Comprehensive Medication Review program can connect you with a CVS Caremark pharmacist who will review your drugs and talk to your doctor about dosages, duration and any other pertinent issues. The pharmacist will work with your doctor to evaluate opportunities to:

- Identify possible drug interactions
- Improve drug adherence
- Reduce gaps in care
- Eliminate duplications in drug therapy

The program works with your doctor to ensure that you are not only taking the best drugs to manage your conditions, but you are also able to take your drugs as prescribed.

Medication Therapy Management Program

Taking medications as prescribed not only helps improve your health but can also reduce your health care costs. CareFirst's Medication Therapy Management program is designed to help you get the best results from your drug therapy.

We review pharmacy claims for opportunities to:

- Save you money
- Support compliance with medications
- Improve your care
- Ensure safe use of high-risk medications

When opportunities are identified, "Drug Advisories" will be communicated to either you and/or your doctor regarding your drug therapy. Through our Pharmacy Advisor program, you may also have the opportunity to speak one-to-one with a pharmacist, who can answer questions and help you manage your prescription drugs.

Should you have any questions about your prescription benefits, please contact CareFirst Pharmacy Services at 800-241-3371.

SUM5041-1P (10/22)

Take the Call

If you're dealing with something health-related—a medical emergency, chronic condition like diabetes, or personal goal such as losing weight—you don't have to go it alone. CareFirst BlueCross BlueShield (CareFirst) is here for you.

As part of your medical benefits, you may receive a call from us (or a letter or postcard in the mail) telling you more about our personal, one-on-one health support programs that can help with whatever you're facing. These programs are confidential, and there's no obligation to participate. But if you decide to take part, you can choose how involved you want to be.

We encourage you to "take the call" so you can take advantage of this personal support.

You don't need to wait for us to contact you. If you would like to learn more about our one-on-one coaching and support programs, visit **carefirst.com/takethecall**.

Confidential, one-on-one support

Below are a few examples of when we might contact you about our personal health programs.

	Program name	Overview	Why it's important	Communication
	**Health & Wellness**	Personal coaching support to help you achieve your health goals	Health coaching can help you manage stress, eat healthier, quit smoking, lose weight and much more.	Letter or phone call from a ***Sharecare coach***
	**Care Management**	Support for a variety of acute and chronic medical conditions and health care concerns and/or supporting transition from hospital to home	Connecting you with a nurse who works closely with your primary care provider (PCP) or specialist to help you understand your doctor's recommendations, medications and treatment plans. The nurse may provide interventions and resources to help you independently manage your health care or transition safely from the hospital to home.	Introduction by PCP or a phone call from a ***Registered Nurse Care Manager***
	**Pharmacy Advisor**	Managing medications for specific conditions	Understanding your condition and staying on track with appropriate medications is crucial to successfully managing your health.	Letter or a phone call from a ***CVS Caremark pharmacy specialist***
	Comprehensive Medication Review	Managing multiple medications	Talking to a pharmacist who understands your medication history can help identify any possible side effects or harmful interactions.	Phone call from a ***CVS Caremark pharmacist***
	Specialty Pharmacy Coordination	Managing specialty medications for chronic conditions	Connecting with a nurse who specializes in your condition provides additional support so you can adhere to your treatment plan for better health.	Letter or phone call from a ***CVS Caremark specialty nurse***
	**Behavioral Health and Substance Use Disorder**	Support for mental health and/or addiction issues	Confidential, one-on-one support to help schedule appointments, explain treatment options, collaborate with doctors and identify additional resources.	Phone call from a ***CareFirst behavioral health care coordinator***

This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst members. CVS Caremark does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the pharmacy benefit management services it provides.

SUM3785-1S (3/22)

Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

The best place to get consistent, quality health care is your primary care provider (PCP). If you have a medical issue, having a doctor who knows your health history often makes it easier to get the care you need.

CloseKnit Virtual Primary Care

Looking for a virtual PCP option? CloseKnit is a virtual-first primary care practice that's part of the CareFirst BlueCross BlueShield network and included in your plan. Learn more at **closeknithealth.com**.

24-Hour Nurse Advice Line

Registered nurses are available 24/7 to discuss your symptoms with you and recommend the most appropriate care. Call 800-535-9700 anytime to speak with a nurse.

CareFirst Video Visit

When your PCP isn't available and you need urgent care services, CareFirst Video Visit securely connects you with a doctor, day or night, through your smartphone, tablet or computer. In addition, you can schedule visits for other needs such as behavioral health support from a therapist or psychiatrist, guidance from a certified nutritionist or breastfeeding support from a lactation consultant. It's a convenient and easy way to get the care you need, wherever you are. Visit **carefirstvideovisit.com** to get started.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer care for non-emergency situations like colds, pink eye, strep tests and vaccinations. These centers usually have evening and weekend hours.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) provide treatment for injuries and illnesses that require prompt medical attention but are not life-threatening (sprains, minor cuts, flu, rashes, minor burns). These centers have doctors on staff and offer weekend/after-hours care.

Emergency room (ER)

Emergency rooms treat acute illnesses and trauma. Go to the ER right away if you or a family member have sudden symptoms that need emergency care, including (but not limited to): chest pain, trouble breathing or head trauma.
Prior authorization is not needed for emergency room services.

*The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

	Sample Cost	Needs or Symptoms	24/7	Rx
24-Hour Nurse Advice Line	$0	If you are unsure about your symptoms or where to go for care, call 800-535-9700, anytime day or night to speak to a registered nurse.		
CloseKnit Virtual Primary Care *(24/7/365 virtual care for members 18+)*	$10	■ Cough, cold and flu ■ Illness while traveling ■ Urgent care needs	✔	✔
Video Visit *(Urgent care services)*	$20	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✔	✔
Convenience Care *(e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)*	$20	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✘	✔
Urgent Care *(Non-life threatening illness or injury requiring immediate care, e.g., Patient First or ExpressCare)*	$60	■ Sprains ■ Cut requiring stitches ■ Minor burns	✘	✔
Emergency Room *(Life-threatening illness or injury)*	$200	■ Chest pain ■ Difficulty breathing ■ Abdominal pain	✔	✔

* The costs in this chart are for illustrative purposes only and may not represent your specific benefits or costs.

To determine your specific benefits and associated costs:

- Log in to *My Account* at **carefirst.com/myaccount**;
- Check your Evidence of Coverage or benefit summary;
- Ask your benefit administrator; or
- Call Member Services at the telephone number on the back of your member ID card.

Did you know that **where** you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

SUM3424-1P (10/22)

CareFirst WellBeing

Putting the power of health in your hands

We're pleased to introduce CareFirst WellBeing℠—your personalized digital connection to your healthiest life. Catering to your unique health and wellness goals, CareFirst WellBeing offers motivating digital resources accessible anytime, plus specialized programs for extra support.

Ready to take charge of your health?

Find out if your healthy habits are truly making an impact by taking the RealAge® health assessment! In just a few minutes, RealAge will help you determine the physical age of your body compared to your calendar age. You'll discover the lifestyle behaviors helping you stay younger or making you age faster and receive insightful recommendations based on your results.

Exclusive features

Our well-being program is full of resources and tools that reflect your own preferences and interests. You get:

- **Trackers:** Connect your wearable devices or enter your own data to monitor daily habits like sleep, steps, nutrition and more.
- **A personalized health timeline:** Receive content and programs tailored to you.
- **Challenges:** Stay motivated by joining a challenge to make achieving your health goals more entertaining.
- **Inspirations:** Break free from stress, unwind at the end of the day or ease into a restful night of sleep with meditation, streaming music and videos.

Download the mobile app to access well-being tools and resources whenever and wherever you want.

*Sharecare, Inc. is an independent company that provides health improvement management services to CareFirst members.

Specialized programs

The following programs can help you focus on specific wellness goals. For more information about any of these programs, please call well-being support at 877-260-3253.

Health coaching

Coaches are registered nurses and trained professionals who provide one-on-one support to help you reach your wellness goals. If you are interested in health coaching or are contacted, we encourage you to take advantage of this voluntary and confidential program that can help you achieve your best possible health.

Weight management program

Improve your overall health, reach a healthier weight and reduce your risk for pre-diabetes and associated chronic diseases.

Tobacco cessation program

Quitting smoking and other forms of tobacco can lower your risk for many serious conditions from heart disease and stroke to lung cancer. Our program's expert guidance, support and online tools make quitting easier than you might think.

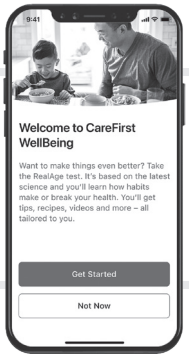
Financial well-being program

Learn how to take small steps toward big improvements in your financial situation. Whether you want to stop living paycheck to paycheck, get out of debt, or send a child to college, our financial well-being program can help.

Additional offerings

- **Wellness discount program**—Sign up for Blue365 at **carefirst.com/wellnessdiscounts** to receive special offers from top national and local retailers on fitness gear, gym memberships, healthy eating options and more.
- ***Vitality* magazine**—Read our member magazine which includes important plan information at **carefirst.com/vitality**.
- **Health education**—View our health library for more health and well-being information at **carefirst.com/livinghealthy**.

To start exploring the program, visit **carefirst.com/wellbeing** to download the CareFirst WellBeing app and register for your account. If you're already registered with Sharecare, you can download the app and log in with your current username and password.



This well-being program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members. Sharecare, Inc. does not provide CareFirst BlueCross BlueShield products or services and is solely responsible for the health improvement management services it provides.

Mental Health Support

Well-being for mind and body

Living your best life means taking care of your body *and* your mind. Emotional well-being is important at every stage in life, from adolescence through adulthood.

When mental health difficulties arise for you or a loved one, remember you're not alone. Help is available and feeling better is possible.

CareFirst BlueCross BlueShield (CareFirst) is here to help. Members have access to specialized services and programs for depression, anxiety, substance use disorders, and more. Our support team is made up of specially trained service representatives, registered nurses, licensed clinicians and care managers ready to:

- Help you find the right mental health provider(s) and schedule appointments
- Connect you with a care coordinator who will work with your doctor to create a tailored action plan
- Find support groups and resources to help you stay on track

To find help, call us at **800-245-7013.**

988 SUICIDE & CRISIS LIFELINE

Our Behavioral Health Digital Resource, powered by 7 Cups, is available 24/7 with access to CareFirst care managers, trained listeners, supportive communities and individualized growth paths. Learn more by logging into your MyAccount and clicking on the Behavioral Health Digital Resource tile.

SUM3223-1P (5/19)

Need Someone to Talk To?

Resources to help you live your best life

It's perfectly normal to face difficult times or some form of mental health challenge during your life. We all do. When it happens, it's important to remember you're not alone. And it's never too late to seek help.

Get confidential mental health support at no cost to you

CareFirst BlueCross BlueShield (CareFirst)—**together with 7 Cups of Tea[1] (7 Cups), the world's largest behavioral health support system**—is pleased to offer a digital resource to help you live your best life.

With the CareFirst Behavioral Health Digital Resource, you can get the emotional care you need, when you need it, 24/7. You can also connect to a caring, accepting community and learn new skills to help you grow stronger.

Be heard, meet great people and feel like you again

If you're a CareFirst member with medical benefits, you can participate and get the mental health support you need in a way that best suits you.

- **Talk with someone who understands**—Access over 430,000 trained, volunteer listeners who, unlike family or friends, don't try to solve problems—they just listen. Through chat-based messaging, you can talk one-on-one about any issues, big or small, whatever's in your heart. *Support is available in more than 140 languages.*
- **Connect with a licensed therapist**[2]—A CareFirst behavioral health care manager can help you make an appointment.
- **Join a support forum**—Be part of a large, accepting community working together to provide a supportive and understanding forum through online discussion boards, specific group chats and moderated chat rooms.
- **Learn new coping skills**—Take small, simple steps to transform your life. Over 35 growth paths teach valuable skills on various topics, including overcoming depression, financial freedom, getting through breakups, grieving, work stress and more.

The help you need is waiting.

To set up your free account, visit carefirst.com/myaccount and enter your CareFirst *My Account* username and password. Once logged in to *My Account*, scroll down to the *Featured Resources* and select the *Behavioral Health Digital Resource* tile. Or, download the 7 Cups app from the Apple and Android stores. After you've registered, simply log in and start your journey to better mental health.

[1] 7 Cups is an independent company that does not provide Blue Cross Blue Shield products or services.

[2] Standard medical benefits apply.

Medical Benefits Options

Effective for plan year July 1, 2023–June 30, 2024

	Triple Option (available only to out-of-state residents)		
The Benefits	**Level 1 BlueChoice Providers**	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-Participating Providers**
DEDUCTIBLE (CONTRACT YEAR)			
	None	None	$500 Individual/$1,000 Family
OUT OF POCKET MAXIMUM (CONTRACT YEAR)			
Medical	$2,000 Individual/$4,000 Family		$4,000 Individual/$8,000 Family
Prescription Drug	$4,600 Individual/$9,200 Family		
HOSPITALIZATION			
Inpatient Facility	10% AB	10% AB	30% AB after deductible
Inpatient Physician	10% AB	10% AB	30% AB after deductible
Outpatient Facility	10% AB	10% AB	30% AB after deductible
Outpatient Physician	10% AB	10% AB	30% AB after deductible
MATERNITY CARE			
Delivery and Facility	10% AB	10% AB	30% AB after deductible
Infertility Services: Artificial Insemination (AI) and In Vitro Fertilization (IVF) (IVF limited to 3 attempts/ live birth up to a lifetime maximum of $100,000)	10% AB	10% AB	30% AB after deductible
EMERGENCY CARE			
Hospital Emergency Room Facility	10% AB	10% AB	10% AB, no deductible
Hospital Emergency Room Physician	10% AB	10% AB	10% AB, no deductible
Urgent Care Center	10% AB	10% AB	30% AB after deductible
MEDICAL SERVICES			
Office Visits for Illness	10% AB	10% AB	30% AB after deductible
Diagnostic X-rays	10% AB	10% AB	30% AB after deductible
Radiation & Chemotherapy	10% AB	10% AB	30% AB after deductible
Laboratory Test	10% AB (Labcorp only)	10% AB	30% AB after deductible
Allergy Testing	10% AB	10% AB	30% AB after deductible
Allergy Treatment/Injections	10% AB	10% AB	30% AB after deductible
Physical, Speech and Occupational Therapy (limited to 100 visits/benefit period combined PT/OT/ST)	10% AB	10% AB	30% AB after deductible
Chiropractic Services (limited to 20 visits/condition/ benefit period)	10% AB	10% AB	30% AB after deductible
Acupuncture	10% AB	10% AB	30% AB after deductible

AB = Allowed Benefit

Medical Benefits Options

	BlueChoice Opt-Out Plus	
The Benefits	**In-Network**	**Out-of-Network**
DEDUCTIBLE (CONTRACT YEAR)		
	None	$300 Individual/$600 Family
OUT OF POCKET MAXIMUM (CONTRACT YEAR)		
Medical	$2,000 Individual/$4,000 Family	$4,000 Individual/$8,000 Family
Prescription Drug	$4,600 Individual/$9,200 Family	
HOSPITALIZATION		
Inpatient Facility	10% AB	30% AB after deductible
Inpatient Physician	10% AB	30% AB after deductible
Outpatient Facility	10% AB	30% AB after deductible
Outpatient Physician	10% AB	30% AB after deductible
MATERNITY CARE		
Delivery and Facility	10% AB	30% AB after deductible
Infertility Services: Artificial Insemination (AI) and In Vitro Fertilization (IVF) (IVF limited to 3 attempts/ live birth up to a lifetime maximum of $100,000)	10% AB	30% AB after deductible
EMERGENCY CARE		
Hospital Emergency Room Facility	10% AB	10% AB, no deductible
Hospital Emergency Room Physician	10% AB	10% AB, no deductible
Urgent Care Center	10% AB	30% AB after deductible
MEDICAL SERVICES		
Office Visits for Illness	10% AB	30% AB after deductible
Diagnostic X-rays	10% AB	30% AB after deductible
Radiation & Chemotherapy	10% AB	30% AB after deductible
Laboratory Test	10% AB (Labcorp only)	30% AB after deductible
Allergy Testing	10% AB	30% AB after deductible
Allergy Treatment/Injections	10% AB	30% AB after deductible
Physical, Speech and Occupational Therapy (limited to 100 visits/benefit period combined PT/OT/ST)	10% AB	30% AB after deductible
Chiropractic Services (limited to 20 visits/condition/ benefit period)	10% AB	30% AB after deductible
Acupuncture	10% AB	30% AB after deductible

AB = Allowed Benefit

Medical Benefits Options

	Triple Option (available only to out-of-state residents)		
The Benefits	**Level 1 BlueChoice Providers**	**Level 2 BlueCross BlueShield PPO Providers**	**Level 3 Participating and Non-Participating Providers**
PREVENTIVE CARE			
Well Baby & Child Care	No Charge	No Charge	30% AB after deductible
Immunization	No Charge	No Charge	30% AB after deductible
Annual Physical Exam	No Charge	No Charge	30% AB after deductible
Annual Gynecological Exam	No Charge	No Charge	30% AB after deductible
Eye Exams	$10 copay at Davis designated vision center (one per plan year)		
Eye Glasses	Discounts available through Davis Vision		
SPECIAL SERVICES			
Hearing Aid Evaluation Test	10% AB	10% AB	30% AB after deductible
Basic Hearing Aid (one every 36 months)	10% AB	10% AB	30% AB after deductible
Home Health Care Visits (limited to 90 days/benefit period; 40 Home Health Aid visits/per benefit period)	10% AB	10% AB	30% AB after deductible
Ambulance	10% AB	10% AB	10% AB, no deductible
Habilitative Services (up to age 19; must be preauthorized after initial visit)	10% AB	10% AB	30% AB after deductible
Surgical Treatment for Morbid Obesity	50% AB	50% AB	50% AB after deductible
MENTAL HEALTH AND SUBSTANCE USE DISORDER			
Inpatient Care	10% AB	10% AB	30% AB after deductible
Outpatient Care	10% AB	10% AB	30% AB after deductible
PRESCRIPTION DRUG PROGRAM			
Prescription Drugs	$10 copay—Generic drugs $35 copay—Preferred Brand drugs $65 copay—Non-preferred Brand drugs Maintenance drugs—2 copays (Mail or Retail)		

AB = Allowed Benefit

Medical Benefits Options

	BlueChoice Opt-Out Plus	
The Benefits	**In-Network**	**Out-of-Network**
PREVENTIVE CARE		
Well Baby & Child Care	No Charge	30% AB after deductible
Immunization	No Charge	30% AB after deductible
Annual Physical Exam	No Charge	30% AB after deductible
Annual Gynecological Exam	No Charge	30% AB after deductible
Eye Exams	$10 copay at Davis designated vision center (one per plan year)	
Eye Glasses	Discounts available through Davis Vision	
SPECIAL SERVICES		
Hearing Aid Evaluation Test	10% AB	30% AB after deductible
Basic Hearing Aid (one every 36 months)	10% AB	30% AB after deductible
Home Health Care Visits (limited to 90 days/benefit period; 40 Home Health Aid visits/per benefit period)	10% AB	30% AB after deductible
Ambulance	10% AB	10% AB, no deductible
Habilitative Services (up to age 19; must be preauthorized after initial visit)	10% AB	30% AB after deductible
Surgical Treatment for Morbid Obesity	50% AB	50% AB after deductible
MENTAL HEALTH AND SUBSTANCE USE DISORDER		
Inpatient Care	10% AB	30% AB after deductible
Outpatient Care	10% AB	30% AB after deductible
PRESCRIPTION DRUG PROGRAM		
Prescription Drugs	$10 copay—Generic drugs $35 copay—Preferred Brand drugs $65 copay—Non-preferred Brand drugs Maintenance drugs—2 copays (Mail or Retail)	

AB = Allowed Benefit

BlueDental PPO Plan

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$25 Individual/ $75 Family	$75 Individual/ $150 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $2,000 maximum	
PREVENTIVE & DIAGNOSTIC SERVICES		
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays (twice per benefit period) ▪ Full mouth X-ray (once per 36 months) ▪ Fluoride treatments (two per benefit period per member) ▪ Sealants on permanent molars (until the end of the year the member reaches the age 19) ▪ Space maintainers (to age 14)	No charge[1]	25% of Allowed Benefit[1]
BASIC SERVICES AND MAJOR SERVICES—SURGICAL		
▪ Direct placement fillings using approved materials (includes posterior teeth) ▪ Non-surgical periodontics ▪ Simple extractions ▪ Periodontal Maintenance (twice per benefit period) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Surgical periodontic services ▪ Oral surgery ▪ General anesthesia rendered for a covered dental service	20% of Allowed Benefit after deductible[1]	40% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE		
▪ Full and/or partial dentures ▪ Fixed bridges, crowns, inlays and onlays ▪ Recementation of crowns, inlays and/or bridges ▪ Repair of prosthetic appliances as required ▪ Dental implants ▪ Nightguards	50% of Allowed Benefit after deductible[1]	65% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES		
▪ For eligible dependents to age 20	50% of Allowed Benefit[1]	65% of Allowed Benefit[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $1,500 combined maximum	

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

MD Benefits issued under policy form numbers: CareFirst of Maryland, Inc.: CFMI/BLUEDENTAL EOC (1/15); CFMI/BLUEDENTAL DOCS (1/15); CFMI/BLUEDENTAL SOB (1/15); CFMI/51+/GC (R. 1/13); CFMI/ELIG/D-V (7/09) and any amendments; Group Hospitalization and Medical Services, Inc.: MD/GHMSI/BLUEDENTAL EOC (1/15); MD/GHMSI/BLUEDENTAL DOCS (1/15); MD/GHMSI/BLUEDENTAL SOB (1/15); MD/CF/GC (R.1/13); MD/CF/ELIG (R. 1/08) and any amendments.

DC Benefits issued under policy form numbers: DC/GHMSI/BLUEDENTAL EOC (1/15); DC/GHMSI/BLUEDENTAL DOCS (1/15); DC/GHMSI/BLUEDENTAL SOB (1/15); DC/CF/GC (1/14); DC/CF/ELIG (1/14) and any amendments.

BlueDental PPO Plus Plan

	In-Network You Pay	Out-of-Network You Pay
DEDUCTIBLE APPLIES TO ALL BASIC AND MAJOR SERVICES*	$25 Individual $75 Family	$25 Individual $75 Family
ANNUAL MAXIMUM APPLIES TO ALL BASIC AND MAJOR SERVICES*	Plan pays $2,000 maximum	
PREVENTIVE & DIAGNOSTIC SERVICES		
▪ Oral Exams (two per benefit period) ▪ Prophylaxis (two cleanings per benefit period) ▪ Bitewing X-rays (twice per benefit period) ▪ Full mouth X-ray (once per 36 months) ▪ Fluoride treatments (two per benefit period per member) ▪ Sealants on permanent molars (until the end of the year the member reaches the age 19) ▪ Space maintainers (to age 14)	No charge from participating dentist[1]	No charge from participating dentist[1]
BASIC SERVICES AND MAJOR SERVICES—SURGICAL		
▪ Direct placement fillings using approved materials (includes posterior teeth) ▪ Non-surgical periodontics ▪ Simple extractions ▪ Periodontal Maintenance (twice per benefit period) ▪ Endodontics (treatment as required involving the root and pulp of the tooth, such as root canal therapy) ▪ Surgical periodontic services ▪ Oral surgery ▪ General anesthesia rendered for a covered dental service	20% of Allowed Benefit after deductible[1]	20% of Allowed Benefit after deductible[1]
MAJOR SERVICES—RESTORATIVE		
▪ Full and/or partial dentures ▪ Fixed bridges, crowns, inlays and onlays ▪ Recementation of crowns, inlays and/or bridges ▪ Repair of prosthetic appliances as required ▪ Dental implants ▪ Nightguards	50% of Allowed Benefit after deductible[1]	50% of Allowed Benefit after deductible[1]
ORTHODONTIC SERVICES		
▪ For eligible dependents to age 20	50% of Allowed Benefit[1]	50% of Allowed Benefit[1]
ORTHODONTIC LIFETIME MAXIMUM	Plan pays $1,500 combined maximum	

[1] CareFirst payments are based on the CareFirst Allowed Benefit. Participating and Preferred Dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for the difference between the Allowed Benefit and their charges.

* Deductible and Annual Maximum Combined In-network/Out-of-network.

Summary of Exclusions: Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

MD Benefits issued under policy form numbers: CareFirst of Maryland, Inc.: CFMI/BLUEDENTAL EOC (1/15); CFMI/BLUEDENTAL DOCS (1/15); CFMI/BLUEDENTAL SOB (1/15); CFMI/51+/GC (R. 1/13); CFMI/ELIG/D-V (7/09) and any amendments; Group Hospitalization and Medical Services, Inc.: MD/GHMSI/BLUEDENTAL EOC (1/15); MD/GHMSI/BLUEDENTAL DOCS (1/15); MD/GHMSI/BLUEDENTAL SOB (1/15); MD/CF/GC (R.1/13); MD/CF/ELIG (R. 1/08) and any amendments.

DC Benefits issued under policy form numbers: DC/GHMSI/BLUEDENTAL EOC (1/15); DC/GHMSI/BLUEDENTAL DOCS (1/15); DC/GHMSI/BLUEDENTAL SOB (1/15); DC/CF/GC (1/14); DC/CF/ELIG (1/14) and any amendments.

BlueVision Plus Summary of Benefits

We're not an eyewear plan. We're an eye care plan.

12-month benefit period

EYE EXAMINATIONS (once per 12-month benefit period)		
Routine Eye Examination with dilation (per benefit period)	No copay	Plan pays $45, you pay balance
FRAMES (once per 12-month benefit period)		
Davis Vision Frame Collection[1]	No copay for over 200 frames	Not applicable
Non-Collection Frame	Plan pays up to $100, you pay balance	Plan pays $45, you pay balance
SPECTACLE LENSES (once per 12-month benefit period)		
Basic Single Vision (including lenticular lenses)	No copay	Plan pays $52, you pay balance
Basic Bifocal	No copay	Plan pays $82, you pay balance
Basic Trifocal	No copay	Plan pays $101, you pay balance
CONTACT LENSES (initial supply; once per 12-month benefit period)		
Medically Necessary Contacts	No copay with prior approval	Plan pays $285, you pay balance
Davis Vision Contact Lens Collection[1]	No copay with evaluation if Collection Lenses are dispensed	Not applicable
Other (Non-Collection) Contact Lenses	Plan pays up to $127, you pay balance	Plan pays up to $127, you pay balance

LENS OPTIONS[3,4] (add to spectacle prices above)			
Digital Single Vision	$30	Anti-Reflective (AR) Coating (Standard/Premium/Ultra/Ultimate)	$35/$48/$60/$85
Tinting of Plastic Lenses (Solid/Gradient)	$0	Progressive Lenses (Standard/Premium/ Ultra/Ultimate)	$50/$90/$140/$175
Scratch-Resistant Coating	$0	High-Index Lenses (1.67/1.74)	$55/$120
Polycarbonate Lenses (Children/Adults)[2]	$0/$30	Polarized Lenses	$75
Ultraviolet Coating	$12	Plastic Photochromic Lenses	$65
Blue Light Coating	$15	Scratch Protection Plan: Single Vision/ Multifocal Lenses	$20/$40
ADDITIONAL DISCOUNTED SERVICES[3,4]			
Retinal Imaging—Member Charge	$39		
DavisVisionContacts.com Mail Order Contact Lens Replacement Online	Discounted prices[3]		
Laser Vision Correction[3]	Up to 25% off allowed amount or 5% off any advertised special[3]		

[1] Collection is available at most participating independent provider offices. Collection is subject to change.

[2] Polycarbonate lenses are covered for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

[3] These discounts are not considered covered benefits under the Plan. This portion of the Plan is not an insurance product. Additional plan discounts may not be available at all provider locations in all states. Please confirm that discounts are accepted when making your appointment. Discounts are not insurance and subject to change without notice.

[4] Available additional discounts not applicable at Glasses.com, 1-800 Contacts, Walmart locations, Sam's Club locations, or Costco locations or where limited by law or manufacturer restrictions.

[5] Reena Mukamal, "20 Surprising Health Problems an Eye Exam Can Catch," American Academy of Ophthalmology, aao.org.

Benefits issued under policy form numbers: Non-rider/Freestanding:

MD: CFMI/51+/GC (R. 1/13) • CFMI/LG/2021 GC AMEND (1/21) • CFMI/EOC/D-V (R. 10/11) • CFMI/VISION DOCS (R. 7/21) CFMI/VISION SOB (R. 7/21) • CFMI/DOL APPEAL (R. 9/11) • CFMI/DB/SPOUSE (10/12) • CFMI/DOM PARTNER (R. 9/11) • CFMI/ELIG/D-V (7/09) • CFMI HEALTH GUARANTY 1/22 • CFMI–DISCLOSURE 10/15 MD/CF/GC (R. 1/13) • MD/CF/LG/2021 GC AMEND (1/21) • MD/CF/EOC/D-V (R. 10/11) • MD/CF/DOCS-V (R. 7/21) • MD/CF/SOB-V (R. 7/21) • MD/GHMSI/DOL APPEAL (R. 9/11) • MD/CF/SPOUSE (10/12) • MD/CF/PARTNER (R. 9/11) • MD/CF/ELIG (R. 1/08) • MD NCA–HEALTH GUARANTY 1/22• GHMSI-DISCLOSURE 10/15

DC: DC/CF/GC (R. 1/13) • DC/CF/LG/2021 GC AMEND (1/21) • DC/CF/EOC/D-V (1/12) • DC/CF/DOCS-V (R. 7/21) • DC/CF/SOB-V (R. 7/21) • DC/CF/ELIG (9/04) • DC/GHMSI/DOL APPEAL (R. 1/22) • DC/CF/PARTNER (R. 7/09) • DC GHMSI – HEALTH GUARANTY 5/21

VA: VA/CF/GC (R. 1/13) • VA/CF/LG/2021 GC AMEND (1/21) • VA/CF/EOC/D-V (1/12) • VA/CF/DOCS-V (R. 7/21) • VA/CF/SOB-V (R. 7/21) • VA/CF/ELIG (R. 1/12) • VA/GHMSI/DOL APPEAL (R. 1/20) • VA/CF/PARTNER (R. 10/11) • VA/GHMSI/HEALTH GUARANTY 7/18 Ridered: CFMI/BLUEVISION PLUS RIDER (7/21) • MD/CF/BLUEVISION PLUS RIDER (7/21) • MD/CFBC/BLUEVISION PLUS RIDER (7/21) • DC/CF/BLUEVISION PLUS RIDER (7/21) • DC/CFBC/BLUEVISION PLUS RIDER (7/21) • VA/CF/BLUEVISION PLUS RIDER (7/21) • VA/CFBC/BLUEVISION PLUS RIDER (7/21)

BlueVision Plus Summary of Benefits

Did you know that eye exams allow eye care professionals to take a non-invasive look inside the body? An eye care professional can detect up to 20 chronic medical conditions during an eye exam, from diabetes and heart disease to hypertension and cognitive dysfunction, even before symptoms occur[5].

How the plan works

Our Plusses

Davis Vision® administers BlueVision Plus. Our vision plans provide an affordable way for members to receive their annual eye exams. And if you need corrective lenses, we have you covered there too.

National Network

More than 121,000 access points across the U.S. accept BlueVision Plus. This includes private practices, retailers, and online retailers such as Visionworks, Walmart, Costco and Glasses.com.

How do I find a provider?

To find a provider, go to **carefirst.com** and use the Find a Provider feature or call Davis Vision for a list of network providers closest to you at 800-783-5602, available seven days a week. Service is available
8 a.m.–11 p.m., Monday through Friday; 9 a.m.–4 p.m., Saturday; and noon–4 p.m. on Sunday.

Be sure to ask your provider if they participate with the Davis Vision network before receiving care.

How do I receive care from a network provider?

Call your provider and schedule an appointment. Identify yourself as a CareFirst BlueVision Plus member and provide the doctor with your identification number, as well as your date of birth. Then go to your appointment and receive care. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer some out-of-network coverage. However, you will be responsible for all payments upfront and need to file a claim with Davis Vision for reimbursement. You must also pay any balances over the allowed benefit to the non-participating provider. Find the claim form at **carefirst.com:** locate *For Members*, then click on *Forms, Vision, Davis Vision.*

Can I get contacts and eyeglasses in the same benefit period?

No. BlueVision Plus covers one pair of eyeglasses OR a supply of contact lenses per benefit period.

When do I get my ID card?

Member ID cards are mailed to your home after enrollment. You can also access your member ID card—along with other claims and benefit information—at *My Account* or on the CareFirst mobile app. Visit **carefirst.com/myaccount** to register.

BlueVision Core vs BlueVision Plus

Some CareFirst members have an embedded vision product called BlueVision Core (exam only with discounts) plan AND a BlueVision Plus plan. To ensure you are receiving your BlueVision Plus benefits look for the **VU indicator on your member ID card**.

Other benefits

- **Access to in-network online retail partners:** Glasses.com, Warby Parker and Befitting
- **Mail order replacement contact lenses:** Davis Vision's mail order contact lens replacement service is powered by ABB Optical Group, the nation's #1 optical distributor and second largest contact lens provider. By accessing **davisvisioncontacts.com**, members can easily order replacement contact lenses at significant savings and have them shipped directly to their doorstep.
- **Hearing aid discounts** through YourHearing Network
- **Free LASIK consultation**
  - **Under $1,000/eye for conventional LASIK** (usually $1,677/eye)
  - **40-50% off** the national average price
  - **1,000 locations nationwide**

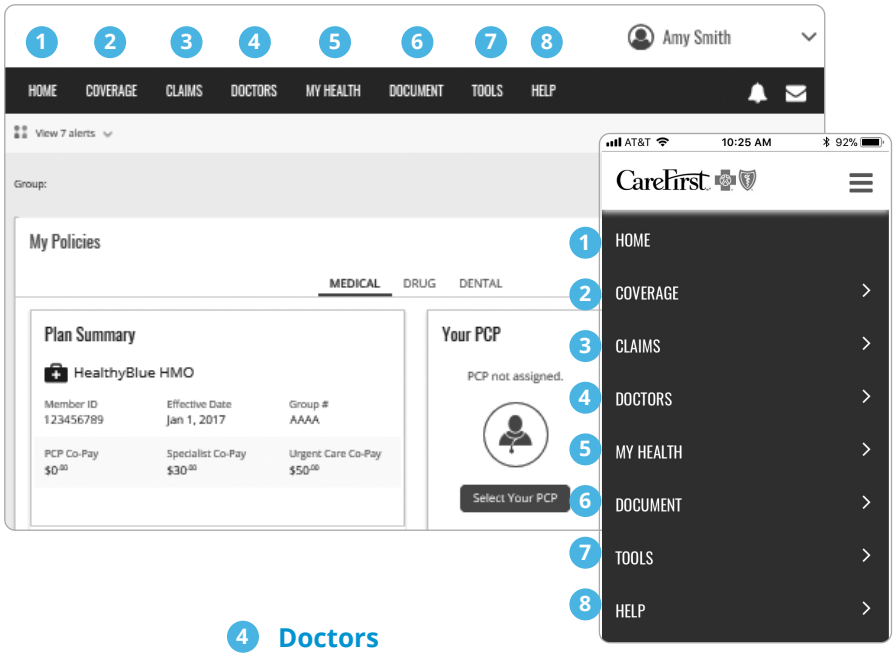
BRC6424-1P (8/17) ■ 12 month/$0 copay ■ BlueVision Plus ■ Option 1_C

My Account

It's easy to manage your health care with My Account

As a CareFirst BlueCross BlueShield (CareFirst) member, your personalized benefit information is available 24/7. Register for *My Account* for secure online access to your coverage details, ID card and more. Plus, you'll also be able to quickly locate in-network providers and facilities nationwide.

Go to **carefirst.com/myaccount** to register.



My Account at a glance

1 Home

- Quickly view plan information including effective date, copays, deductible, out-of-pocket status and recent claims activity
- Manage your personal profile details including password, username and email, or choose to receive materials electronically
- Send a secure message via the *Message Center*
- Check *Alerts* for important notifications

2 Coverage

- Access your plan information—plus, see who is covered
- Update your other health insurance information, if applicable
- View, order or print member ID cards
- Review the status of your health expense account (HSA or FSA)[1]
- Order and refill prescriptions
- View prescription drug claims

3 Claims

- Check your claims activity, status and history
- Review your Explanation of Benefits (EOBs)
- Track your remaining deductible and out-of-pocket total
- Submit out-of-network claims
- Review your year-end claims summary

4 Doctors

- Find in-network providers and facilities nationwide, including specialists, urgent care centers and labs
- Select or change your primary care provider (PCP)
- Locate nearby pharmacies

5 My Health

- Access health and wellness discounts through Blue365
- Learn about your wellness program options[1]
- Track your Blue Rewards progress[1]

6 Documents

- Look up plan forms and documentation[2]
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[3]
- Use the drug pricing tool to determine prescription costs

8 Help

- Find answers to many frequently asked questions
- Send a secure message or locate important phone numbers

[1] Only if offered by your plan.

[2] Only available when using a computer.

[3] The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

Flexible Spending Accounts

American Fidelity Assurance Company

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
$30,000	Annual Gross Income	$30,000
- $2,400	Healthcare FSA Election	$0
- $2,500	Dependent Care Account Election	$0
$25,100	Taxable Gross Income	$30,000
- $5,020	Estimated Federal Tax (20%)*	- 6,000
- $1,920.15	Estimated FICA (7.65%)	- 2,295
$18,159.85	Annual Net Income	$21,705
$0	Cost of Medical Expenses	- $2,400
$0	Cost of Dependent Care Expenses	- $2,500
$18,159.85	**Spendable Income**	**$16,805**
With an FSA, potential annual savings in this example is: $1,354.85		

By using an FSA to pay for eligible expenses, you can reduce your taxable income.

* Estimated state 5% and federal 15%.

Healthcare Flexible Spending Account (Healthcare FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

Minimum Annual Election: Determined by your employer Maximum Annual Election: Internal Revenue Code allows up to $2,750 per plan year, but your employer will determine amount.

Examples of Eligible Expenses for Healthcare FSA

Copays/coinsurance

Deductibles

Dental treatments

Diabetic supplies

Prescription drugs and medicines

Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme

Flu shots

Immunizations

Lab fees

Laser/Lasik/RK surgery

Medical exams

Orthodontia

Psychiatric care

Wheelchair

X-rays

For a more complete list of eligible expenses, please visit www.americanfidelity.com

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Flexible Spending Accounts

Benefits Debit Card

Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.

Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFmobile® app makes this easy.

- **Snap** a photo of the itemized receipt* with your phone.
- **Submit** the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- **Go**! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

*The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

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Flexible Spending Accounts

American Fidelity Assurance Company

Dependent Care Account (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work. Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

Minimum Annual Election: Determined by your employer.
Maximum Annual Election: While the IRC allows a maximum of $5,000 per year, the employer may set the maximum equal to or lower than this amount.

Examples of Eligible Dependent Care Expenses

After-school care or extended day programs

Nanny expenses

Baby-sitter inside or outside participant's household

Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household

Dependent Day Care center* expenses/pre-kindergarten/nursery school expense

Expenses paid to a non-dependent relative of participant to care for the child

Summer day camp if the primary purpose of the expense is custodial in nature and not educational

For a more complete list of eligible expenses, please visit www.americanfidelity.com.

**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

Regardless of whether you participate in the Dependent Care Account under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are generally allowed a 90-day run-off period after the plan year ends to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
  1. Prepay the contributions on a pre-tax basis, or
  2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you contiune to receive enough pay, or
  3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

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Flexible Spending Accounts

Managing Your Account

File a Claim

Three Easy Ways

1. **On your mobile device using AFmobile®**

Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. **Online at americanfidelity.com**

3. **By mail or fax**

Insurance Claim
American Fidelity Assurance Company, Attn: Benefits Department
P.O. Box 268898, Oklahoma City, OK 73125
Fax: 800-818-3453

FSA and HRA Claim
American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968, Altamonte Springs, FL 32716
Fax # 844-319-3668

*Obtain a claim form for your insurance claim at www.americanfidelity.com/fileaclaim.

Manage Your Reimbursement Account With AFmobile®

AFmobile® allows FSA and HRA participants to submit reimbursement account claims while on the go.

- Access accounts - check balances, view transaction history, and more.
- Manage claims - submit new claims, upload receipts, and check claims status.
- Receive account alerts - choose to receive account updates by text and push notifications.
- Submit documentation - tie receipts and other documentation to a pending card swipe to expedite adjudication.

Getting Started:

Download AFmobile. To register, you will need:

- Your email address - this should be the same email address provided at time of enrollment.
- Your Social Security Number.

Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts and insurance benefits.

Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

Three ways to sign up for direct deposit:

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form

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Definitions

These definitions have been developed to help you become familiar with some of the terms in this manual.

Allowed Benefit

The criteria CareFirst BlueCross BlueShield uses to determine payments to your physician. It is based upon the Resource Based Relative Value Unit System. This system takes 3 factors into consideration; work value (amount of skill/time/effort required for service), practice expense (cost of overhead expenses), and the liability/malpractice expense for covered services.

Card (Identification/Membership)

Identification or membership card for medical/pharmacy coverage and/or dental. The card identifies the employee, types of elected coverage, type of membership and the effective date of coverage.

Coinsurance

A cost-sharing requirement under your CareFirst BlueCross BlueShield policy which requires you to assume a percentage of the costs of covered services.

Copay

Cost sharing in which you pay a flat amount per service. Unlike coinsurance the amount does not vary as a percentage of the cost of the service.

Deductible

Amount of expense you must incur before CareFirst BlueCross BlueShield will assume any liability for all or part of the remaining cost of covered services.

Eligibility

State of fulfilling requirements for coverage.

In-network Provider

A preferred provider within a Preferred Provider Organization.

Medical Emergency

The sudden and unexpected onset of a serious illness or condition which requires necessary, immediate medical care.

Non-Participating Provider

A physician or other provider who has not signed an agreement with the CareFirst BlueCross BlueShield plan to accept the Allowed Benefit as payment in full.

Out-of-Network Provider

A provider that is not part of the PPO network

Out-of-pocket

The deductible copayment plus any coinsurance amount that the subscriber pays; once this has been met the policy will normally pay at 100% of the Allowed Benefit for most covered services.

Participating Provider

Individual physicians, hospitals and professional health care providers who have a contract with CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. to provide services to its members at a discounted rate and to be paid directly for covered services.

Medical Plan Year

The Plan Year is twelve months July 1–June 30.

Dental Plan Year

The Plan Year is twelve months July 1–June 30.

Professional Component

That portion of a charge for x-ray or laboratory services performed in a hospital which is allocated to a physician as his professional fee.

Provider

An individual or institution that provides medical care.

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 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 ìṣẹ́ 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.

Notice of Nondiscrimination and Availability of Language Assistance Services

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 ɓɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɋé nì ɓíɖí-wùqù mú ɓɛ́ m̀ ké se wídí 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 pàɋàìn hwè. Ɔ jǔ ké nyɔ ɋò dyi m̀ gɔ̃ jǔǐn, po wuqu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɋò mu ɓó nììn ɓɛ́ ɔ ké nì wuquɔ̀ 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。

Notice of Nondiscrimination and Availability of Language Assistance Services

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 niká'ádoowoł 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. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

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