CareFirst
Family of health care plans

Vitality

YOUR 2025/2026 MEMBER RESOURCE GUIDE



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Vitality is published annually by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, "CareFirst"). The articles in *Vitality* are not intended as medical advice. For your individual healthcare needs, you should consult with your doctor or other provider. The benefit information presented in *Vitality* is a general description of coverage. It is not a contract and certain exclusions and limitations may apply. Your detailed coverage information is available in your benefit guide or by logging in to My Account at **carefirst.com/myaccount**. If you have questions about your coverage or need to update your mailing address, call Member Services at the telephone number on the back of your member ID card.

2025 WORLD'S MOST ETHICAL COMPANIES® ETHISPHERE 13-TIME HONOREE

CareFirst is proud to be recognized as one of the World's Most Ethical Companies® for 13 consecutive years.

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WELCOME

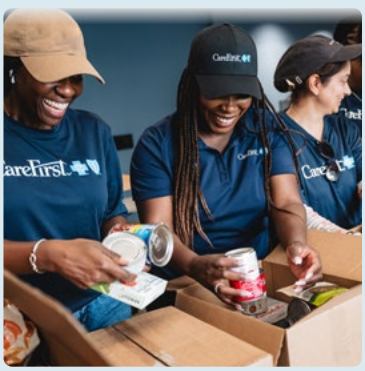
At CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, "CareFirst"), we understand personal health is deeply intertwined with the health of the community. That's why we're committed to investing in the places our members call "home."

As part of our commitment, we provide resources like *Vitality* to help you get the most from your CareFirst plan. Inside, you'll find essential information to support you along your healthcare journey. In addition, we invite you to take advantage of the resources below:

- **Healthcare anywhere**—CloseKnit, a virtual-first care practice, offers primary care as well as urgent care, behavioral health, nutrition services and new parent support. In-person locations available in some areas. Learn more at **carefirst.com/closeknit**.
- **Protecting your privacy**—As part of our commitment to keeping your personal and health information safe online, we developed a new website—**carefirst.com/cybersecurity**—to inform you of all things privacy-related.
- **Making sense of health insurance**—You don't need to be an insurance expert to take advantage of it. But knowing the basics can help you make more informed decisions. We can help. Visit **carefirst.com/healthinsurance101** to get started.









Care starts in our communities.

As a not-for-profit healthcare company serving more than 3.5 million members, CareFirst is uniquely positioned to make a meaningful difference in our communities. In 2024, our employees logged nearly 90,000 hours of volunteer service. Investing our energy, time and money in the places where we live, work and play is at the heart of who we are—because when the health of our community is good, everyone benefits.

Scan the code to explore the highlights of our 2024 community efforts to ensure everyone has an equal opportunity to be healthy and live fully.

ONLINE RESOURCES

My Account

My Account makes it easy to understand and manage your health plan and benefits 24/7. By setting up an account, you'll have password-protected access to:

- Find and select in-network doctors, specialists, dentists and behavioral health providers—including hospitals, urgent care centers, labs and imaging facilities
- View copays and identify other expenses for which you may be responsible
- View, order or print your member ID card
- Check the status of claims, remaining deductibles and out-of-pocket totals
- Opt in to get communications electronically—click on your name at the top of the page and select *Communication Preferences*



Need to register for My Account?

Getting started is easy! Go to **carefirst.com/myaccount** and select *Register Now*. Then, follow the steps to complete your registration.

CareFirst WellBeing℠

CareFirst WellBeing is your digital connection to your healthiest life. This program features all the tools, resources and support you need to manage every aspect of your well-being, including physical fitness, family relationships, health coaching, stress management and financial health.

Get started today by visiting **carefirst.com/wellbeing**.

Find a Doctor

You can search for various providers, including primary care providers, specialists, mental or behavioral health care, dental and vision providers or healthcare facilities. Go to **carefirst.com/findadoc** to begin. Then, personalize your search by filtering on any of the following:

- Provider name
- Provider specialty
- Location and distance
- Gender
- Languages spoken
- Group and hospital affiliations
- Accepting new patients
- Patient ratings and awards

To confirm a provider participates in your plan's network, log in to My Account to conduct your search. By registering for and logging in to My Account, the Find a Doctor tool will automatically provide in-network search results based on your plan type.

Want a printed copy of the provider directory or information about providers? Call Member Services at the telephone number on the back of your member ID card.

ACCESSING CARE

Accessing care with your plan

It's important to understand how to access care. In your benefits document, you can find specific information, such as:

- How do I access primary care, specialty care, mental or behavioral health care or hospital services?
- Is a referral needed to see a specialist or to receive treatment?
- Does the service or procedure require preauthorization?

Before obtaining treatment at a hospital, facility or lab, ask your physician where they have privileges to practice and determine if those locations participate with your plan.

Visit **carefirst.com** to compare and research hospitals. Select *For Members* at the top of the page, then click *Find Providers*, then *Compare and Research Doctors and Hospitals*. For a personalized experience, log in to **My Account** and select *Doctors* in the main menu, then *Find a Doctor*.

If you need assistance with accessing care, call Member Services at the telephone number on the back of your member ID card.

Complex care management

CareFirst's complex care management services help reduce the frustration of fragmented care that those with acute and complex needs often face. Your care manager can coordinate your medical care, help you understand your condition and share resources to help you make more informed decisions.

The complex care management team registered nurses (RNs), social workers and clinical support associates can help:

- Enhance the quality of life for you and your family
- Contribute to your sense of well-being and dignity
- Positively influence the quality of your healthcare
- Coordinate services for adult and pediatric members
- Empower you and your family members through education

"[My Care Manager] was incredible in giving me support throughout with all my care and doctors and [the] coordination of doctor visits. It made my life so much easier."



When you enroll in the program, a care manager will:

- Call you for an initial review of your medical history to identify the factors that may affect your health
- Review your progress and answer any of your questions
- Provide support during your time of need
- Provide you with information and self-care tips related to your condition
- Assist with identifying community resources and support groups available to you
- Work closely with your doctor to coordinate necessary services including Hospice and Palliative Care

Talk with your primary care physician (PCP) today to enroll in complex care management. You may also call CareFirst's team at 833-536-2004 and select the appropriate option.



Options for care

Establishing a relationship with a PCP is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention.

If you have a life-threatening injury, illness or emergency, call 911 or go directly to the nearest emergency room.

Below is a chart with other choices for care, including some options that are available anytime day or night.

YOUR CARE OPTIONS	COST	NEEDS OR SYMPTOMS SUCH AS	24/7	RX	VIRTUAL CARE	IN-PERSON CARE
CloseKnit Virtual Care* 24/7/365 virtual-first primary care, urgent care, mental health and other specialty services **in-person care available in some areas*	$	▪ Preventive visits ▪ Urgent care ▪ Mental health therapy ▪ Psychiatry for ages 2+ ▪ Lactation consultation ▪ Nutrition and diet support ▪ Billing and benefits support	✔	✔	✔	✔
24-Hour Nurse Advice Line Call 800-535-9700 for general questions about health issues or where to go for care	$0	▪ Cough, cold and flu ▪ Rashes ▪ Medication questions	✔	✘	✔	✘
PCP Visit Discuss diagnosis, treatment of illness, chronic conditions, routine check-ups	$	▪ Routine physical ▪ Diabetic care ▪ Cough, cold, flu, allergies ▪ Bronchitis	✘	✔	✔	✔
Convenience Care Health screenings, vaccinations, minor illness or injury	$$	▪ Cough and cold ▪ Pink eye ▪ Ear pain ▪ Flu shot	✘	✔	✘	✔
Urgent Care Non-life-threatening illness or injury requiring immediate care	$$$	▪ Sprains ▪ Cut requiring stitches ▪ Minor burns ▪ Sore throat	✘	✔	✘	✔
Emergency Room Life-threatening illness or injury	$$$$$	▪ Chest pain ▪ Difficulty breathing ▪ Uncontrolled bleeding ▪ Major burns	✔	✔	✘	✔

Out-of-area care

For members with BlueChoice HMO plans and BlueChoice Plus or Opt-Out plans

Outside the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia, in-network benefits are available for emergency or urgent services. In addition, some plans (such as BlueChoice Plus and BlueChoice Opt Out) provide out-of-network coverage for other covered services. Refer to your benefits guide for more information.

When you see an out-of-area participating BlueCross BlueShield (BCBS) doctor or hospital for emergency or urgent care, you only pay out-of-pocket expenses (e.g., a copayment). Your provider files the claim, which is paid at the in-network level. If your plan provides out-of-network benefits, non-emergency or urgent care covered services are paid at the out-of-network benefit level.



Need to find a provider?

Using a provider in the CareFirst network offers many advantages including lower out-of-pocket costs. To help you find an in-network provider, we suggest you use our Find a Doctor tool at **carefirst.com/findadoc**.

Members who will be out of town for 90 days or more are eligible for the Away From Home Care® program. This program is ideal for travelers, students who live at school or families who live apart. Program members enjoy a full range of benefits, including routine and preventive care. Your copayment and benefits will be the same as those of the affiliated HMO in the area you are visiting. You will be treated as a member of the affiliated plan.

For more information or to enroll in the Away From Home Care program, call Member Services at the number on your ID card and ask for the Away From Home Care coordinator.

For members with BlueChoice Advantage

BlueChoice Advantage plans provide in-network coverage for other covered services when a member uses available providers in the BlueCard® PPO network. Some plans access BCBSA select networks in some jurisdictions. These plans also include out-of-network coverage. Refer to your benefits guide for more information.

For members with PPO plans

Outside the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia, benefits are available for healthcare services. If you have a Preferred Provider Organization (PPO) plan, in-network benefits are available for covered services rendered by providers who participate in the PPO plan of another Blue Cross and Blue Shield (BCBS) plan. Non-emergency and urgent treatment care from providers not in a BCBS PPO plan is eligible for out-of-network benefits.

When you arrive at the doctor's office or hospital, present your CareFirst member ID card. After you receive medical attention, your provider will file the claim. CareFirst pays all participating and preferred doctors and hospitals directly. You are only responsible for out-of-pocket expenses (i.e., non-covered services, deductibles, copayments or coinsurance).

If the provider does not participate with a BCBS plan and you must pay at the time of service, contact Member Services or visit the Using Your Plan section of **carefirst.com** to get a claim form for reimbursement of the charges.

Advance directives

Provided by the Maryland Department of Health (MDH). CareFirst is required to publish this information for members in Maryland, but it may be helpful to all members.

Regardless of age or health status, a medical crisis could leave you too ill or injured to communicate decisions about your healthcare. Thinking about the types of treatment you would or wouldn't like and potential outcomes is important before a medical crisis occurs. Start the conversation with family, friends, healthcare providers, an attorney, or religious advisor.

Advance care planning—discuss

Advance care planning is an ongoing conversation with people you trust to discuss your personal preferences and decisions that might need to be made in a medical crisis, not just end-of-life care. Advance care planning requires careful consideration of your values, religious beliefs, preferences for treatment, and acceptable outcomes, which are documented in an advance directive or a Medical Orders for Life-Sustaining Treatment (MOLST) form. An advance directive is not the same as a MOLST form; to learn more about the Maryland MOLST form, visit **www.miemss.org/home/molst**. These conversations make your wishes known so they can be honored in the event you have limited or no capacity to make decisions for yourself. This eases burden on family and loved ones and helps prevent conflicts about your care. Identifying who can speak on your behalf is important—in Maryland, this individual is called a healthcare agent. If you don't appoint a healthcare agent, your next of kin will be designated under law to make decisions for you if you can't speak for yourself.

Advance directive—record

You have the option to create an advance directive, a useful and legal way to direct your medical care when you can't speak for yourself. You can appoint a healthcare agent to make decisions on your behalf and specify your treatment preferences in future situations, such as when to use life-sustaining treatments. Pick someone you trust to make these serious decisions and talk to that person to make sure they accept the responsibility. Include their name and contact information and any back-up healthcare agents in your advance directive. Various advance directive forms are available from healthcare providers, religious organizations, estate planners, lawyers, and others. There is no one form that must be used; you can personalize your advance directive to fit your wishes. Make sure to provide a copy of your advance directive to your family, healthcare providers, lawyer, or anyone else who should be aware of your decisions. Remember—you are not required to have an advance directive, and you can revoke your advance directive and complete a new one at any time.

Electronic documentation—share

An advance directive can be most effective if you make it available in electronic form that is easily accessible by a healthcare provider. Talk to your healthcare provider about storing a copy of your advance directive and healthcare agent information in their secure electronic health record system. You may be able to add and update this information outside of clinical visits using the healthcare provider's patient portal, a secure online website where you can view your health record and communicate with your care team. You can also use a State Recognized electronic advance directives service to create, upload, share, and update your advance directive and healthcare agent information. Learn more about how healthcare providers involved in your care can access your information at **crisphealth.org/for-patients/#advance-directives**.

More information about how to get started with your advance directive, including sample forms, is available on the Maryland Attorney General's website: **www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx**.

Referrals and prior authorization

Not all CareFirst plans require referrals, but the Maryland Point of Service (MPOS) plan and some HMO and BlueChoice plans do.

- **MPOS**—All MPOS members must first choose a PCP. Then you must obtain a referral from your PCP before your specialist visit to receive in-network benefits. MPOS members can see a specialist without a referral but may pay more out of pocket.
- **HMO and BlueChoice**—Most BlueChoice plans do not require a referral to see a specialist. However, if your plan requires a referral, your PCP must provide the referral prior to your visit with a specialist.

Referrals may be for a single visit or multiple visits, also referred to as a standing referral. Standing referrals may be issued if the patient has a specific condition such as:

- A cancer diagnosis, to see a board-certified pain management physician
- A pregnancy, for maternal care and delivery
- A condition that is life-threatening, degenerative, chronic or a disability
- Requires specialized medical care

For members in all plans, your doctor must request authorization prior to services such as non-emergency hospitalizations, outpatient hospital services and home healthcare.

To determine if your plan requires referrals or authorizations, or for questions about how your benefit plan works, you can:

- Log in to **My Account** and check your benefit details,
- Refer to the benefits guide you received when you enrolled, or
- Call Member Services at the telephone number on the back of your member ID card.

Accessing non-network providers

Many of CareFirst's plans offer out-of-network coverage, typically costing the member more. However, there are some situations where a member may not have access to a network provider and may be able to access a non-network provider at a network cost share for deductible, copayment and coinsurance.

Under HMO and non-HMO plans, a member may request authorization to be treated by a non-network specialist if CareFirst does not have in its network a specialist or non-physician specialist with the professional training and expertise to treat or provide healthcare services for the condition or disease; or if CareFirst cannot provide reasonable access to a network specialist or non-physician specialist with the professional training and expertise to treat or provide healthcare services for the condition or disease without unreasonable delay or travel.

When access to non-network providers is authorized for the situations described herein, the service is treated as if it was provided by a network provider for purposes of calculating the member's deductible, copayment and coinsurance.

If you are unable to find a network provider with the expertise or without unreasonable delay or travel, contact Member Services at the telephone number on the back of your member ID card to initiate your request.

Initial determinations for non-emergency authorizations are made within two working days of receipt of the information necessary to make a decision. Urgent authorization decisions are made within 24 hours of receipt of the request.

Grievance and appeal process

If you have a concern regarding the denial of an authorization, you may call the Member Services telephone number on the back of your member ID card. A representative can help you initiate the appeal process. If you want to review the procedure for filing an appeal, visit **carefirst.com/appeals**. For a printed copy, call Member Services at the telephone number on the back of your member ID card.

PRESCRIPTION MEDICATIONS

Prescription drug benefits

Our formulary structure

A formulary is a list of prescription drugs covered by your plan. The prescription drugs covered on the CareFirst formulary are reviewed and approved by the Pharmacy and Therapeutics (P&T) Committee, an independent national committee comprised of physicians, pharmacists and other healthcare professionals. This committee reviews the drugs on the formulary to ensure they are safe and clinically effective. Drugs may be added to the formulary monthly, and drug exclusions and tier changes may occur on a quarterly basis. If there is a change to the formulary, impacted members are notified via letter. The drugs are categorized into tiers (see chart below) and your cost share is determined by that tier. Each plan has different tiers, so check your benefits guide to see what tiers your plan includes.

Generic dispensing

Generic drugs meet the same U.S. Food and Drug Administration (FDA) standards as brand-name drugs; both are safe and effective, but generics typically cost significantly less. Brand-name drugs may be substituted with a generic drug equivalent when available. The brand-name drug can be requested; however, your cost share may increase depending on the generic dispensing option (voluntary, restrictive or mandatory) that is part of your prescription benefit plan. Refer to your benefit summary or enrollment materials for more information.

This is an example of a 5-tier formulary structure:

DRUG TIER (COST SHARE)	COST	DEFINITION
Tier 0	**$0**	Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, HIV PrEP, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. Oral chemotherapy drugs, opioid overdose reversal agents and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share. Deductible may apply.
Tier 1 Generic	**$**	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	**$$**	Preferred brand drugs are brand-name drugs that may not be available in generic form but are chosen for their cost-effectiveness compared to alternatives. Your cost share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3 Non-Preferred Brand	**$$$**	Non-preferred brand drugs often have a generic or preferred brand drug option where your cost share will be lower.
Tier 4 Preferred Specialty	**$$$$**	Preferred specialty brand drugs are specialty brand-name drugs that may not be available in generic form but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred specialty brand drugs. If a generic drug becomes available, the preferred specialty brand drug may be moved to the non-preferred specialty brand category.
Tier 5 Non-Preferred Specialty	**$$$$$**	Non-preferred specialty drugs often have a specialty drug option where your cost share will be lower.



Questions about your prescription benefits?

To view your drug list and find out more about your prescription benefits, you can:

- Log in to **My Account** and view the Drug & Pharmacy Resources section;
- Check your enrollment materials; or
- Call the Pharmacy telephone number on the back of your member ID card.

If you need language assistance or have questions or complaints about your pharmacy benefits, call the Member Services telephone number on the back of your member ID card.

Prescription drug benefits (continued)

Prescription guidelines

Some medications are only intended to be used in limited quantities. Others require your doctor to obtain prior authorization through CareFirst before they can be filled.

- **Prior authorization** may be required before you fill prescriptions for certain drugs. Your doctor may need to provide your medical history or laboratory tests before they can be filled. Without prior authorization approval, your drugs may not be covered.
- **Quantity limits** are placed on selected drugs due to safety or quality concerns or to discourage unnecessary overutilization. Limits may be placed on the amount of the drug covered per prescription or for a defined period. If your doctor decides that a different quantity of medication is right for you, your doctor can request prior authorization for coverage.
- **Step therapy** ensures you receive a cost-effective drug option as the first step in treating certain health conditions. When similar drugs are available, step therapy guides your doctor to prescribe the most cost-effective option first. Higher step drugs may require prior authorization by your doctor before they can be covered.

Our Drug Pricing Tool can tell you whether any of these restrictions apply to your medications. You'll find the Drug Pricing Tool on My Account, CareFirst's member portal.

Exception requests

Some drugs may not be covered on your formulary. An excluded drug always has an alternative drug option in the same drug class on the formulary. There is an exception process if you need an excluded drug to be covered for medical necessity reasons. Your doctor may submit an exception request by fax or electronically.

If an exception request is approved, your drug will be covered and a notice will be sent to you and your doctor. If an exception request is denied, a notice will be sent to you and your doctor explaining the reason why the request was denied along with information on how to submit an appeal.

PLAN COVERAGE

Benefit information

When you joined your health plan, you received enrollment materials, including a benefits guide and a PCP selection form, if applicable. These documents include information about how and where to get primary, specialty and emergency healthcare, pharmacy and related services. They also include information on premium changes, policy renewability and employers' responsibilities for dependent coverage.

When you have questions about your benefits, including what's covered, what's not covered, benefit restrictions and more, there are several ways to find the information:

- Log in to My Account at **carefirst.com/myaccount** from your computer or mobile device.
- Refer to the benefits document you received when you enrolled.
- If you have coverage through your employer, ask your benefits office.
- If you do not have internet access, call Member Services at the telephone number on the back of your member ID card.

Sometimes, changes to your health plan may result in new information that may not be reflected in your enrollment materials. For the most current information, you should log in to My Account at **carefirst.com/myaccount**.

Continuation of coverage

As a CareFirst member, you may have options for continuing your healthcare coverage if your employment status changes. Your options may include the following:

- Consolidated Omnibus Budget Reconciliation Act (COBRA): For information, contact your company's health benefits administrator.
- State continuation plan: For information, contact your company's health benefits administrator.
- Individual plan: Call 800-544-8703 for details, including benefit options.

Submitting claims

When you obtain services from a provider or pharmacy participating in CareFirst's network, the provider's office or the pharmacy will submit claims for you. However, if you visit a non-participating provider or non-participating pharmacy for service, you must submit the claim yourself. You can submit your claim by mail or online.

Submit your claim form online

CareFirst offers online claims submission for medical, dental and mental or behavioral health care claims. From your computer or mobile device, log in to My Account and select *Claims*. Choose *Submit a Claim Online*, then *Submit a Claim*. Follow the prompts, upload the required documents and submit.

Mail your claim form

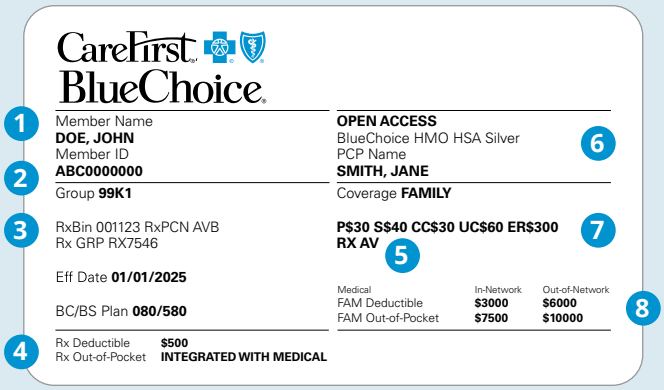
To print and mail your claim form, log in to My Account, select the *My Documents* tab, and choose *Forms*. Choose the form for your type of claim and fill in the required information. Then, mail the form using the directions included. If you do not have internet access, you can request a paper claim form by calling Member Services at the telephone number on the back of your member ID card.

Understanding your member ID card

Your member ID card—like the example shown here—identifies you as a CareFirst member and shows important information about you and your covered benefits. Each family member on your plan should have a card with his/her name on it. Make sure to always present your ID card when receiving services. If you don't have your physical card, you can view it on your smartphone through My Account.

This graphic shows the most requested information when you receive care. In addition, you will find important telephone numbers on the back.

Make sure the information on your card is correct. If there is an error, call Member Services at the telephone number on the back of your member ID card.



1 & 2 **Member ID & Group #**—these are the numbers providers will ask for to verify your coverage

3 **Codes**—pharmacies use these to route claims for payment

4 **Prescription deductible and out-of-pocket maximums**

5 **Additional coverage**—
RX=drug
AV=adult vision

6 **Plan and PCP name**—your plan and primary care provider's name

7 **Copay amounts**—abbreviations correspond to your plan copays:
P=primary care provider
S=specialist
CC=convenience care
UC=urgent care
ER=emergency room

8 **Medical deductible and out-of-pocket maximums**

Submitting an appeal, grievance or complaint

Appeals or grievances

If you have concerns regarding a decision that adversely affects coverage, such as a denial, reduction of benefits, or denial of authorization for services, you may call the Member Services telephone number on the back of your member ID card. A representative can assist you with resolving the issue or initiating the appeal process. If needed, language interpretation is available.

If you would like to review the procedure for filing an appeal, visit **carefirst.com/appeals**. For a printed copy, call Member Services at the telephone number on the back of your member ID card. In addition, many members have a right to an independent external review of any final appeal or grievance decision. Refer to your Evidence of Coverage for more specific information regarding initiating an external review, a final appeal determination or a complaint.

Quality of care complaints

You may submit a complaint using any of these methods:

- Call Member Services at the telephone number on the back of your member ID card. If you have trouble understanding English, please tell the representative, and we will have an interpreter who speaks your preferred language join the call.
- Send an email to **quality.care.complaints@carefirst.com**.

Notice of privacy practices

CareFirst is committed to keeping the financial and protected health information of members private. Under the Gramm Leach Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to have policies and procedures in place to protect your financial and protected health information, whether oral, written or electronic. Additionally, we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of your financial and protected health information, the individual's rights and our responsibility for ensuring the privacy of your information.

To obtain a copy of our Notice of Privacy Practices, please visit our website at **carefirst.com** or call the Member Services telephone number on your member ID card. Members of self-insured groups should contact their Human Resources department for a copy of the company's Notice of Privacy Practices. Please contact your Human Resources department if you don't know whether your employer is self-insured. CareFirst sends the Notice of Privacy to all policyholders upon enrollment.

Below is a summary of our Notice of Privacy Practices.

Our responsibilities

We are required by law to maintain the privacy of your financial and protected health information and to have appropriate procedures in place to do so. We are also required to notify you following a breach of your unsecured protected health information. In accordance with the federal and state privacy laws, we have the right to collect, use and disclose your financial and protected health information for payment activities and healthcare operations. In addition, we may use or disclose your information for health benefits administration purposes (such as claims and enrollment processing, care management and wellness offerings, claims payment, and fraud detection and prevention efforts) and our business operations (including for quality measurement and enhancement and benefit improvement and development) as explained in the Notice of Privacy Practices.

Personal contact information and telephone numbers, including mobile numbers, may be used and shared with other businesses that work with CareFirst to administer and/or provide benefits under this plan and to notify members about treatment options, health-related services and/or coverage options.

Where permitted by law, we may disclose your financial and protected health information to the plan sponsor/employer to perform plan administration functions. We also may disclose protected health information for national priority purposes.

For most purposes other than those described in this summary, a valid authorization from you is required before we may use or disclose your financial and protected health information.

Your rights regarding protected health information

You may request in writing the following:

- A copy of your protected health information that is contained in a designated record set pertaining to your medical record
- That we restrict the protected health information we use or disclose about you for payment or healthcare operations
- That we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your protected health information may endanger you
- That we amend your information if you believe your protected health information is incorrect or incomplete
- An accounting of disclosures of your protected health information for reasons other than payment or healthcare operations

Notice of privacy practices (continued)

Inquiries and complaints

A member may complain to CareFirst if the member believes that CareFirst has violated their privacy rights. A member also may file a complaint with the Secretary of Health and Human Services. If you have a privacy-related question or complaint, you may contact the CareFirst Privacy Office at:

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
Privacy Office CT 10-03
10455 Mill Run Circle
Owings Mills, MD 21117
800-853-9236
Fax: 410-505-6692
Email: **privacy.office@carefirst.com**



Members' rights and responsibilities

CareFirst is committed to maintaining a mutually respectful relationship with you. Our Rights and Responsibilities policy acknowledges our responsibilities to you and outlines your obligations as a member. Understanding your rights and responsibilities will help you make the most of your membership and relationship with CareFirst.

To find the full list of your rights and responsibilities, visit **carefirst.com/myrights**. For a printed copy of the Members' Rights and Responsibilities, call Member Services at the telephone number on the back of your member ID card.



Notice of information sharing to enhance or coordinate your care

This notice describes how medical information and data about you may be shared between CareFirst and your treating providers to enhance or coordinate your care. Please read it carefully.

Note: References to CareFirst include CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., and all of their corporate affiliates (collectively, "CareFirst").

Why we may share information

The more complete information your healthcare providers have, the better they can meet your healthcare needs. Sharing information and data with your treating providers can lead to better-coordinated care, help you get timely care, limit duplicative services, and help them better identify patients who would benefit most from care management and other care coordination programs.

How we use medical information to enhance or coordinate your care

To administer your health benefits, CareFirst receives claims data and other information from your various care providers regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from your other providers. When CareFirst has such information, it may share it with your treating providers through secure, electronic means solely for purposes of enhancing or coordinating your care and to assist in clinical decision-making.

- This information may include healthcare claims information or medical data resulting from medical encounters, treatments, diagnostic tests, screenings, prescriptions, or Patient-Centered Medical Home and other complex care management programs and activities. It may also include the results of your Health Risk Assessment and/or Wellness Screening provided through a contracted CareFirst healthcare partner.
- Information received by CareFirst from your providers for the sole purpose of enhancing or coordinating your care cannot be used for purposes of underwriting, utilization review or setting rates on your health insurance. You cannot be denied insurance or lose your coverage based on the information shared by your treating providers with CareFirst for care coordination purposes.

Notice of information sharing to enhance or coordinate your care (continued)

- The sharing of this information is also subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state privacy laws. You have been provided notice of your privacy rights under HIPAA as part of CareFirst's Notice of Privacy Practices. The restrictions on sharing medical information discussed in your HIPAA notice and your rights under HIPAA continue to apply.

You may opt out of information sharing for these care coordination purposes

You have the right to opt out of sharing this information by CareFirst with your treating provider for care coordination purposes at any time. To opt out, complete, sign and return the Opt Out of Information Sharing form. You can find the form at **carefirst.com/informationsharing**.

When you submit this form, you also end participation in any of the programs listed in this notice that require sharing information to enhance or coordinate care. If you opt out, your treating providers will not have access to the data or information CareFirst has available to help enhance or coordinate your care.

This Notice of Information Sharing is in accordance with CareFirst's Privacy Practices. For a copy of CareFirst's Notice of Privacy Practices, see page 14 of this guide. For questions or a copy of this notice, the Opt Out form or CareFirst's Notice of Privacy Practices in writing, contact:

CareFirst BlueCross BlueShield
Attention: Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
800-853-9236
Fax: 410-505-6692
Email: **privacy.office@carefirst.com**



Developments in medical technology and your benefits

To ensure our members have access to safe and effective care, CareFirst reviews new developments in medical technology and new applications of existing technology for inclusion as a covered benefit. We routinely evaluate new and existing technologies through a formal review process. CareFirst clinicians and researchers consider input from medical professionals in the community, government agencies and published scientific studies to determine if they are medically appropriate.

Experimental medical care is defined as medical, behavioral health and surgical treatments, supplies and technology that are in the developmental stage and are in the process of human or animal testing. Services, supplies or technology that do not meet all five (5) of the criteria listed below adopted by the BlueCross BlueShield Association (BCBSA) Medical Policy Services (MPS) Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center" criteria) are deemed to be experimental/investigational:

- The technology must have final approval from the appropriate U.S.[1] government regulatory body,
- The scientific evidence permits conclusions concerning the effect of the technology on health outcomes,
- The technology improves the net health outcome,
- The technology is as beneficial as any established alternatives, and
- The improvement is attainable outside the investigational settings.

[1] The BCBSA criteria indicates the technology must have final approval from the appropriate government regulatory bodies; however, CareFirst BlueCross BlueShield ("CareFirst") requires the technology receives final approval from the appropriate U.S. government regulatory body.

Member coverage and rate information

Every year, CareFirst is required to publish this notice informing you of your benefits for the following services, along with proposed rate increase information.

Habilitative services

CareFirst provides coverage for habilitative services.

In Maryland, habilitative services consist of services and devices, including occupational therapy, physical therapy and speech therapy, which help a child keep, learn or improve skills and functioning for daily living.

In Washington, D.C., habilitative services apply to occupational therapy, physical therapy and speech therapy for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

Please note that the benefits provided by habilitative coverage in both jurisdictions do not include services to a child provided under an individualized education program (IEP) or any obligation imposed on a public school by the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended periodically.

Before obtaining treatment, check your benefits document to determine if you or your dependents are eligible to receive these benefits since age restrictions may apply.

CareFirst must pre-approve all habilitative services. Any deductibles, copayments and coinsurance required under your benefits guide apply. Policy maximums and benefit limits may apply. Habilitative services are not counted toward any visit maximum for therapy services.

If you have questions regarding any of these services, call Member Services at the telephone number on the back of your member ID card.

Care for mothers, newborns

Under the Newborns' and Mothers' Health Protection Act, CareFirst offers coverage for inpatient hospitalization services for a mother and newborn child for a minimum of:

- 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery
- 96 hours of inpatient hospitalization care after an uncomplicated cesarean section

If the mother and newborn remain in the hospital for at least the length of time provided, coverage includes a home visit if prescribed by the attending physician. The mother may request a shorter length of stay if, after talking with her physician, she decides that less time is needed for her recovery.

If the mother and newborn have a shorter hospital stay than listed above, coverage includes one home visit scheduled to occur within 24 hours after hospital discharge and an additional home visit if prescribed by the attending physician.

Mastectomy

CareFirst provides coverage for a minimum 48-hour inpatient hospital stay following a mastectomy.

If the member remains in the hospital for at least the time provided, coverage includes a home visit if prescribed by the attending physician. The member may request a shorter length of stay if, after talking with her physician, she decides that less time is needed for her recovery.

If the member has a shorter hospital stay than listed previously, coverage includes one home visit scheduled to occur within 24 hours after discharge, plus an additional home visit if prescribed by the attending physician.

This coverage notice applies only to policies sold to businesses and individuals in Maryland. Please check your benefits document to determine whether you are eligible for these surgical procedure benefits.

Mastectomy-related services

CareFirst offers benefits for mastectomy-related services under the Women's Health and Cancer Rights Act of 1998, including:

- All stages of reconstruction of the breast that underwent the mastectomy
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis (artificial breast) and treatment of the physical complications that occur at all stages of the mastectomy, including lymphedema (swelling)

You and your physician will determine the appropriate plan to treat your condition. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits covered under your health plan. Please refer to your benefits document for more details or call Member Services at the telephone number on the back of your member ID card.

Mental or behavioral health and substance use disorder services notice

Maryland law requires health insurance carriers to provide specific information about mental or behavioral health and substance use disorder benefits to their members enrolled in Maryland individual plans or Maryland fully insured groups; however, this information should be helpful to all members.

Members can view their mental health and substance use disorder benefits online. To do so, log in to My Account at **carefirst.com/myaccount**. If you have not registered, please follow the steps indicated online. Once you have logged in, visit the *Coverage* tab at the top of the page and select *Benefits Details.* The benefits shown only reflect current benefits.

Mental or behavioral health and substance use disorder benefits are compliant with Maryland law and/or federal law and vary whether you purchase your plan or have a plan through your employer.

If you require additional information about mental or behavioral health and substance use disorder benefits as required by Maryland law, please contact the Maryland Insurance Administration (MIA) online at **insurance.maryland.gov** or call 410-468-2000. If you wish to write the MIA, the address is 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

NOTE: You may authorize CareFirst in writing to share your mental or behavioral health information with a third party, such as a family member, employer, lawyer, broker or unrelated party, by completing and submitting an authorization form. Call Member Services at the telephone number on the back of your member ID card to request the Authorization Form for Information Release. You will receive the form by standard mail within 10 business days after CareFirst receives the request.

Home visits

CareFirst provides coverage for home visits to members who undergo the surgical removal of a testicle. Coverage includes one home visit within 24 hours after discharge from the hospital or outpatient facility and an additional home visit if prescribed by the member's doctor.

To be eligible, the member must be in the hospital for less than 48 hours or have the procedure performed on an outpatient basis. This coverage notice applies only to policies sold to businesses and individuals in Maryland. Please check your benefits document to determine whether you are eligible.

Proposed rate increase notice

Maryland law requires health insurance companies, health maintenance organizations (HMOs), and nonprofit health service plans to file rates and have them approved by the Maryland Insurance Administration (MIA) before the rates go into effect.

The proposed rates are posted on the MIA's website at **insurance.maryland.gov**.

Once the proposed rate increases are posted, Maryland consumers have a 30-day public review period to submit comments on the MIA's website. Once the MIA completes its review process and makes a final decision on any rate filings, a summary of the results is posted on its website.

NOTE: Proposed rates for the Federal BlueChoice plan are negotiated directly with the Office of Personnel Management.

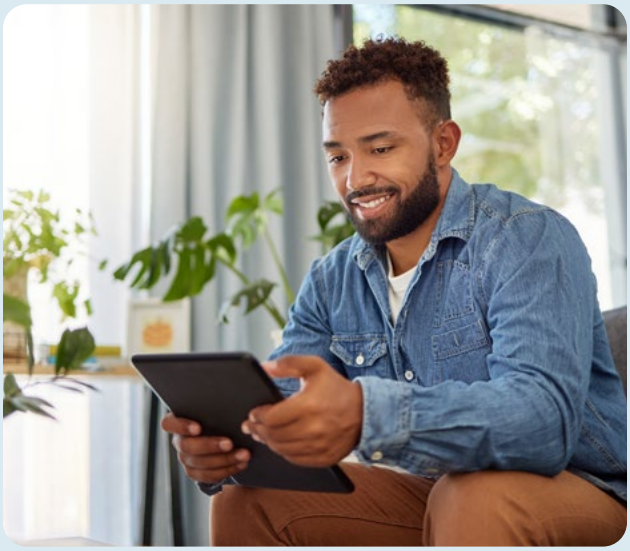
COMMUNICATIONS ASSISTANCE

Language and communication assistance

If you have trouble understanding English, please tell the representative when you call Member Services, and we will have a translator who speaks your preferred language join the call. We can provide you with information about your benefits, how to access medical services and help answer any other questions.

If you have a hearing or speech impairment, please dial 711 to place a call to Member Services.

If you need assistance communicating with your provider(s) at an in-person appointment, you may call Member Services at the telephone number on the back of your member ID card, and we will connect you with a translator. This service is available at no additional charge to you or your provider(s).



Need to register for My Account?

Signing up is quick and easy.
It only takes a few minutes!

Go to **carefirst.com/myaccount** and select *Register Now*. Then, follow the steps to complete your registration.

With My Account, you'll have secure online access to tools and information personalized just for you, day or night.

To register, you'll need:

- Your member ID number
- The last four digits of your social security number (SSN) or taxpayer identification number (TIN)

Notice of non-discrimination and availability of language assistance services

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 14858 Lexington, KY 40512
Email Address	civilrightscoordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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