CareFirst
Family of health care plans



Patient-Centered Medical Home (PCMH) Program Description & Guidelines

2026

Pediatric Medicine

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Key Terms and Definitions

Collaborative Panel	A CareFirst made Panel for PCPs who are unable to find their own Panel
Credits	A Panel's Performance Year budget, or expected cost of care of their attributed Members
Debits	Allowed amount of healthcare spend for Members attributed to a Panel in the Performance Year
Designated Provider Representative (DPR)	Primary Care Prover (PCP) lead for the Panel who has certain administrative responsibilities
Episode of Care Debit Overlap	50% of the shared savings earned by specialists in an Episode of Care value-based model that is applied back to a Panel's Patient Care Account
Identification Stratification Population	Group of CareFirst Members who meet specific criteria related to care coordination needs
Individual Stop Loss	Portion of Gross Debits representing 100% of costs Per Member Per Year (PMPY) above $50,000 debited back to the Patient Care Account
Member	CareFirst beneficiary of Medical and Pharmacy Benefits
Member Months	The number of individual months a CareFirst Member is attributed to a PCMH Panel
Outcome Incentive Award	Portion of shared savings awarded to eligible Panels and practices who meet savings to budget, quality score, engagement and attribution requirements
Overall Medical Trend	Change in the total cost of care over time for CareFirst Members with the CareFirst Medical Benefit
Overall Pharmacy Trend	Change in the total cost of pharmacy claims for the CareFirst Members with the CareFirst Pharmacy Benefit
Panel	Group of Primary Care Providers formed for participation in the PCMH Program
Panel Governance	CareFirst committee that reviews Panel structure, appeals and exceptions
Participation Incentive	12 percentage point increase to standard base fee schedule for PCPs participating in the PCMH Program
Patient Care Account	A report that presents a Panel's budget and total healthcare spend in a Performance Year
Performance Year	The measurement period for PCMH ranging from January 1 through December 31 of any given year
Persistency	Increase in Outcome Incentive Award total for Panels who earn an Outcome Incentive Award multiple years in a row; awarded at levels of 2 or 3+ years in a row
Provider Directory	A list of providers contracted to participate in the CareFirst network available to CareFirst Members

Panel Size

A Panel, or group of Pediatricians, is the basic performance unit of the Pediatric PCMH Program ("Program"), forming a team where one otherwise may not exist. PCMH Participation Incentives and Outcome Incentive Awards (OIAs) are based on the performance of Panels.

To form a Panel, Pediatricians must organize into a group of five to 15. A Panel may be formed by an existing group practice, small independent group practices, and/or solo practitioners that agree to work together to achieve Program goals. When a Panel is between five and 15 Pediatricians, it is large enough to reasonably pool member experience for the purpose of pattern recognition and the generation of financial incentives, yet small enough for each Pediatrician's contribution to be perceived as meaningful. The idea is to tie rewards as directly as possible to individual Pediatrician performance while providing enough experience to support sound conclusions about overall performance for each Panel.

Nurse Practitioners (NPs) are considered to be Pediatricians and count towards the minimum of five Pediatricians required to comprise a Panel.

Practices that exceed 15 Pediatricians but practice in the same location may request in writing to CareFirst an exception to form one Panel. This request will be reviewed by Panel Governance to determine the appropriateness of the exception based on the following criteria:.

1. Panel Viability
2. Geography
3. Panel Cohesion/Accountability
4. Point in the Performance Year of the Request

CareFirst reserves the right to deny additions that result in Panels larger than 15 Pediatricians in size.

If the termination of a practice or individual Pediatrician within the Panel causes a Panel to fall below minimum participation requirements of five Pediatricians, the Panel will have up to one year to restore itself to the minimum participation level of five Pediatricians.

Panel Viability

For performance results to be credible, a Panel must have a minimum level of 15,000 attributed Member Months over the course of the Performance Year, or an average of 1,250 attributed Members per month. This is the point at which a Panel is considered viable and therefore eligible to earn an OIA.

There may be some instances when Panels are not able to reach the number of attributed Members needed to be viable while staying within the permissible range of five to 15 Pediatricians per Panel. For example, a Panel located in a geographic area with a low volume of CareFirst Members may not have enough Members to be considered viable. In these instances, the Panel may request to add additional Pediatricians, with the approval of CareFirst, to exceed the 15 Pediatrician maximum and achieve a viable Panel size.

In some circumstances, a pediatrician may have difficulty finding a Panel to join. In these instances, CareFirst will assign a Pediatrician to a PCMH Collaborative Panel. Practices joining the PCMH Program without a prospect to become a viable Panel that meets the Program requirements are agreeing to be placed in a Collaborative Panel. The Collaborative Panels will be constructed to ensure viability requirements are met. As such, CareFirst may construct a Panel that exceeds the 15 Pediatrician maximum and may be geographically spread.

CareFirst reserves the right to deny the addition of Pediatricians beyond 15 and addition of any Pediatrician to a Collaborative Panel.

Panel Composition

A Pediatrician is eligible for this Program if (s)he is a healthcare provider who: (i) is a full-time, duly licensed medical practitioner; (ii) is a participating provider, contracted to render primary care services, in both the CareFirst BlueChoice Participating Provider Network (HMO) and the CareFirst Regional Participating Preferred Network (RPN); and (iii) has a primary specialty in:

- Pediatrics
- Family Practice (Pediatric Members Only)
- Nurse Practitioners – Pediatrics

No partial group practices are accepted into the PCMH Program. All practitioners who function as a pediatrician must join the Program or the practice will not be accepted. In addition, all providers in the same practice must participate in the same provider networks. Those who do not function as a Pediatrician—such as those who are "floaters" or see urgent care/sick care—should not enroll in the PCMH Program.

Multi-specialty groups may also join the Program, but for the purposes of Panel formation and enhanced payments, only the Pediatricians in such practices may participate. If a Pediatrician who is part of multispecialty group practice seeks to join the Program, all qualifying Pediatricians within the practice must agree to join in order to qualify for Program participation.

CareFirst considers NPs to be critical providers of primary care services and an option for enhanced access for CareFirst Members, and NPs are encouraged to participate in the PCMH Program. NPs who bill for professional services in their own name will have Members attributed to them, just as any other Pediatrician, earning the 12 percent % Participation Incentive and OIA if eligible. Alternatively, NPs who bill "incident to" a physician in the practice will not have any attributed Members, as these Members will appear under the name of the physician under whom the NP is billing.

NPs must comply with all statutory and regulatory obligations to collaborate with or operate under the supervision of a physician pursuant to applicable state and local laws. The inclusion of NPs is intended to provide Members with an expanded choice of providers. Physicians collaborating with NPs participating in the Program must also participate in the PCMH Program.

NPs may also form a Panel of their own, independent of physicians.

Panel Types

There are five types of Panels participating in the PCMH Program.

Virtual Panel: A Virtual Panel is a voluntary association of small, independent group and/or solo practices formed by contract with CareFirst. The Pediatricians in the Panel agree to work together to provide services to CareFirst Members, use each other for coverage and work as a team in improving outcomes for their combined CareFirst population. CareFirst reviews and approves the formation of all Virtual Panels. Pediatricians in these Panels should practice within a reasonably proximate geographic distance from each other to ensure meaningful interactions among Pediatrician Panel members.

Independent Group Practice Panel: An Independent Group Practice Panel is an established group practice of Pediatricians who can qualify as is, because the practice falls within the required size range of five to 15 Pediatricians.

Multi-Panel Independent Group Practice: A Multi-Panel Independent Group Practice is a practice with more than 15 Pediatricians that is not employed by a Health System. All such practices are required to identify segments of five to 15 Pediatricians that constitute logical parts of the larger practice—for example,

pediatric or adult, and/or by location. CareFirst reviews and approves the division of the practice into constituent Panels.

Multi-Panel Health System: A Multi-Panel Health System is under the ownership of a hospital or Health System and consists of more than 15 Pediatricians. All such systems are required to identify segments of five to 15 Pediatricians that constitute logical parts of the larger system—typically by location and population served. CareFirst reviews and approves the division of the system into constituent Panels.

Collaborative Panel: Collaborative Panels are formed at CareFirst's sole discretion. In these instances, CareFirst will assign a Pediatrician to a PCMH Collaborative Panel in order to meet a Member attribution count of 1,250 or greater. As CareFirst will assign Pediatricians to these Panels, the Pediatricians of a collaborative Panel may not decide to remove a Pediatrician from the Panel. These Panels are not required to meet in person and may participate in Panel meetings by teleconference. All other Program requirements will remain the same for Collaborative Panels, including Quality Scorecard, engagement and savings to budget requirements to earn an OIA.

Panel Peer Types

To ensure more meaningful and consistent comparisons in Panel performance and data reporting, Panels are assigned to an Adult or Pediatric peer group, effective in 2019. Separate, customized programs have been established for Adult and Pediatric Panel Peer Types. Mixed Panels have been eliminated. Pediatricians caring for Members of all ages will only be measured on their Members in the corresponding peer type.

PCP Access

Pediatricians must be accessible to all CareFirst Members. However, there are times when a Practice or an individual Pediatrician is "closed" (not accepting new Members) due to capacity limits. A practice or individual Pediatrician within the PCMH Program is required to have an open Practice unless they are closed to all payers. If a practice is open to any other payer for any of its networks, it must be open to all CareFirst Members. However, a practice/Pediatrician may have an open practice for CareFirst and a closed practice for other payers.

Concierge Practices

Pediatricians who require CareFirst Members to participate in a private fee-based program on a concierge basis or require Members to pay any type of retainer, charge, payment, private fee or purchase additional benefits in order to receive services from the Pediatrician, other than the deductibles, co-pays and coinsurance under the terms of the Member's CareFirst benefit contract, do not qualify for the Program.

Pediatricians who charge any fees for supplemental services beyond those covered by CareFirst, and who warrant that the fees charged are strictly voluntary and not required, must agree to and comply with the following conditions, in writing, before acceptance into the Program:

1. The Panel Pediatricians must make it clear that no fee, charge or payment of any kind is required of a CareFirst Member in order to become and/or remain a Member attributed to the Pediatrician or medical practice (other than the payment of ordinary deductibles, copays and co-insurance under the Member's CareFirst benefit contract);
2. There must be no differences in the treatment, care, access, responsiveness, engagement, communications, etc., provided to CareFirst Members who do not pay the fee compared to those who pay the fee;

3. The Panel Pediatricians must set up office procedures and processes in such a way that a Member could not misconstrue a voluntary fee for supplemental services as a requirement to receive covered services; and
4. The Panel Pediatricians must recognize and agree that CareFirst maintains the right to audit compliance with these assurances, which may include a survey of the Pediatricians and medical practices' members who are CareFirst Members.

If CareFirst determines that any Pediatrician or medical practice has not abided by these requirements, the Pediatrician, medical practice and/or Panel will be subject to immediate termination from the Program and will forfeit any additional reimbursements or incentives they may otherwise be entitled to.

Exceptions to the rules regarding concierge practices may be negotiated on a case by case basis according to CareFirst's need for access in a particular geography or to meet particular market needs.

Online Connectivity and Systems Requirements for Pediatricians

The PCMH Program is designed to empower Pediatricians and/or their Care Management Team(s) with the tools and data to effectively manage the care of their members without placing a technology burden on the practice. The PCMH Searchlight SearchLight System is available via CareFirst's provider website. Member-level detail is available in the Care Management Platform, Guiding Care via the PCP's Director of Regional Care Management.

To access the CareFirst Provider Portal, a valid User ID/Password is required, in addition to a computer meeting standard internet access with a current browser. Please contact CareFirst Help Desk (410-998-6400) or **ProviderCFDAccess@carefirst.com** for additional assistance.

Eligibility for PCMH Participation Incentive

A Panel or practice becomes effective in the PCMH Program 60 days following CareFirst's receipt of a complete PCMH application and signed network contract addendum from the whole Panel. Enrollment with a retroactive date is not allowed.

Once effective, CareFirst will add 12 percentage points to professional fees for all practices in the Panel as an incentive for participation in the Program, known as the Participation Incentive. The Participation Incentive continues for as long as PCPs in the Panel meet all engagement requirements and Quality Scorecard minimums, as discussed below in the Quality Measurement Program Requirements section. Participation Incentive and OIAs (if any) do not apply to time-based anesthesia, supplies and injectable drug fees/billings. These additional fees are advance payments intended to fund the practice's work on transformation, including time to meet with CareFirst staff, reviewing data, and redesigning workflow to achieve optimal outcomes and value in the Program. If Panels do not invest in a way that achieves outcomes and value, the Participation Incentive is at risk of reduction or elimination. More details can be found in the Eligibility for Participation Incentive section below.

One note to be clear: The 12-percentage point Participation Incentive is added to Base Fees, not multiplied against them, and may be reduced if certain conditions are not met.

The Participation Incentive is contingent upon meeting quality score and engagement requirements in the PCMH Program and will terminate upon the effective date of a practice's or Panel's termination from the Program. In this event, the payments to the practice will revert to the then-current CareFirst HMO and RPN fee schedules applicable to the practice without any incentives or Participation Incentives.

Measuring a Panel's Total Cost of Care vs. Trend Target

Success in the PCMH Program is determined by a Panel's ability to keep the global spend within a yearly trend target. An expected budget is set each Performance Year, built from the Panel's global medical and pharmacy spend in a Base Period, and adjusted for changes in Overall Medical Trend and Overall Pharmacy Trend, the relative risk of the Panel's patient population, and the Panel's attributed Members.

Base Period

The Base Period for Panels is the average Per Member Per Month (PMPM) Medical and Pharmacy Costs from a two-year period prior to the Performance Year. In PY2019, CareFirst moved to a two-year rolling Base Period no more than three years prior to the Performance Year. The two-year Base Period reduces volatility and reflects the realities of changes in the local health market. At the start of each Performance Year, the Base Period will shift forward one year and will be restated using the Panel's current PCP composition, lessening the impact of market shifts and adjusting for provider movement across Panels.

For PY2021, 2022, and 2023, CareFirst moved away from the rolling Base Period to avoid using inappropriate Base Years affected by the COVID-19 pandemic. PY 2025 will have a Base Period of 2022 and 2023. This Base Period put the PCMH Program back on track with changes made in PY2019. Overall Medical Trend, Pharmacy Trend, and Illness Burden will be adjusted forward from 2022 and 2023, and all adjustment for changes in Panel composition will be applied as described above.

Risk Adjustment

Since the start of the PCMH Program, CareFirst has used the industry-leading DxCG (Diagnostic Cost Grouper) Intelligence to calculate the Medical Illness Burden Score (IBS) for Medical Budget calculation. In an effort to further align with local and national value-based programs, the PCMH Program made plans in PY2020 to move to U.S. Department of Health and Human Services (HHS) Hierarchical Condition Category (HCC) Coding to measure risk. After a detailed analysis of both risk adjustment tools, it was determined that DxCG model captures a larger set of diagnosis and is a more precise risk adjustment tool for setting Panel budgets. DxCG will continue to be used to set PCMH Panel budgets in PY2026 and moving forward.

DxCG or "Diagnostic Cost Grouper" means the risk model known as DxCG Intelligence, a system developed by Cotiviti, Inc (formerly known as Verisk Health) for assessing and predicting healthcare costs based on patient health data. Beginning with Performance Year 2026, CareFirst will transition from Pharmacy Risk Grouper (PRG) to Diagnostic Cost Group (DxCG) for both medical and pharmacy risk . CareFirst will calculate Member's risk score using the most recently available version of DxCG as appropriate. Any changes to the applicable risk score measurement methodologies will be applied to the Base Period with respect to calculations for that Performance Year, in order to ensure that the measures are comparable.

Member Attribution

Attribution of Members will occur on a monthly basis using a 24-month claims lookback period. Plurality of PCP office visits will determine the attributed provider for each Member. Claims history is used to determine a plurality of visits first over the most recent 12 months and then, if necessary, over the preceding 12 months. In the case of a tie for either period, attribution is assigned to the provider with the most recent visit. Effective 2021, Member self-selection is no longer used to attribute Members to Panels. Therefore, in the case of no visits in the 24-month period, a Member will remain unattributed until they visit a PCMH PCP. Attribution for Adult Panels is restricted to Members age 18 and older, while attribution for Pediatric Panels is restricted to ages 20 and younger.

PCMH Attribution will supersede attribution for all other CareFirst value-based programs.

A visit will only impact attribution if an evaluation and management code is submitted from a primary care place of service. Video and audio only calls may impact attribution if the appropriate evaluation and

management codes are submitted. Vaccinations, such as COVID-19 and flu shots, or COVID-19 testing will not impact attribution unless an evaluation and management service is included.

Setting Budget Targets

Budgets for the 2026 Performance Year will be calculated using the Base Period (2023 and 2024) PMPM Medical and Pharmacy costs. Those PMPMs are then risk adjusted and trended forward to create the budget for the 2026 Performance Year population. In 2026, CareFirst will use actual Medical and Pharmacy trends specific to CareFirst's adult population. At the start of the Performance Year, a trend target will be established to set the Panel's budget and will be adjusted to match the actual trend at the end of the Performance Year. Trends will be set based on the portion of health care spending controlled by the owner of the Panels, as described below. Trend targets will adjust each year to bring growth in health care costs in line with wage inflation.

- Independent Panels
  - Medical: CareFirst Medical trend minus 1 percentage point
  - Pharmacy: CareFirst Rx trend minus 1 percentage point
- Health System Panels
  - Medical: CareFirst Medical trend minus 2 percentage points
  - Pharmacy: CareFirst Rx trend minus 2 percentage points

Adult Panels participating in the PCMH Program will have a trend factor based on the CareFirst trend specific to the adult population. See *PCMH Program Description & Guidelines—Adult Medicin*e for details.

Pediatric Exclusions

Some routine and catastrophic costs are excluded when creating the budget targets described above in order to effectively measure success within a pediatric population. The rationale for each exclusion is described below.

Required and Preventive Care

Pediatricians encounter a large and growing body of requirements each year, particularly for Members under the age of two. A Panel is not successful if they reduce cost by sacrificing evidence-based care. Practices should have the ability to accept newborns without fearing they will be negatively impacted. Therefore, starting in 2019, required and preventive care will be budget neutral and excluded from the Base Period and Performance Year through the age of two.

CareFirst developed a list of required and preventive care based on American Academy of Pediatrics guidelines, analysis of claims data from our pediatric Members, and input from our Pediatric Medical Advisors. The list includes immunizations, well-child visits, wellness screenings, and other routine preventive procedures.

With the understanding that some of this care may not be provided exactly by the 2nd birthday, there will be a grace period of two months built into the exclusions.

Additionally, vaccines will be excluded from the Panel budgets regardless of the age of the patient when service is rendered.

The full list of excluded services and relevant CPT codes can be provided upon request. These services are excluded in the Base Period and the Performance Year when billed for a Member aged 26 months or younger.

Newborn Admissions

Admissions that occur within 14 days of life will remain excluded. Often these admissions are direct transfers to the NICU—occurring before the Pediatrician has established a relationship with the Member–—and cannot be prevented.

Additionally, newborn admissions tend to disproportionately impact Health System Panels adept at managing complex Members.

Catastrophic Costs (Individual Stop Loss)

In most Pediatric Panels, very ill Members are rare. One or two can skew a budget. Specialists are often the primary caregivers in these cases, reducing the opportunity for co-management.

In order to mitigate the impact of outliers, Individual Stop Loss (ISL) Protection has been applied at 100% once a Member reaches a predetermined value. In continuing to evolve the Pediatric PCMH Program in response to feedback from providers, we have decided to keep the ISL at a stable value of $50,000 in total spend for a Performance Year. For 2026, costs are capped at $50,000 for Members attributed to Pediatric Panels. This will allow pediatric providers to stay focused on preventive care costs and feel empowered to make the best decisions needed for their more complex patients.

Panels and pediatric providers are still responsible for Members that reach the cap from a quality perspective and are expected to utilize our clinical programs to support their care as appropriate.

Calculating Savings to Budget

Savings compared to expected is calculate at the end of the performance year for each Panel. Panels that have less net Debits than Credits may be eligible to share in the savings in the form of an Outcome Incentive Award (OIA). The net Debits is the total allowed amount for the attributed patient population of the Panel in the Performance Year minus the Individual Stop Loss and Episode of Care Debit Overlap.

Quality Measurement Program Requirements

In addition to cost savings to budget, Panels must achieve clinical quality measures to be successful in the PCMH Program. CareFirst has selected quality measures that drive the most impactful health outcomes and align with those of other payers' programs where possible to maximize provider focus and minimize conflicting coding burdens.

CareFirst Core Pediatric Quality Measures

Measures will now include process-based and outcomes-based measures collected through claims and clinical data sharing. Measures may require attestation, clinical data sharing and survey responses in order for a Panel to achieve all Quality Scorecard points. Details of the inclusion and exclusion criteria for each measure can be found in the CareFirst Quality Toolkit. The 2026 CareFirst Core Quality Measures for Pediatric Panels are shown below.

2026 PCMH Pediatric Core 10 Measures	Source	HEDIS Measure ID	Measure Point Value
1. Well-Child Visits			15
Well-Child Visits in the First 15 Months of Life	NCQA	W30	5
Well-Child Visits in the First 30 Months of Life	NCQA	W30	5
Child and Adolescent Well-Child Visits	NCQA	WCV	5
2. Immunizations for Adolescents—Combination 2	NCQA	IMA	15
Tetanus, Diphtheria Toxoids and Acellular Pertussis (Tdap)	NCQA		
Meningococcal	NCQA		
Human Papilloma Virus (HPV)	NCQA		
3. Childhood Immunization Status—Combo 10	NCQA	CIS-E	10
Diphtheria, Tetanus and Acellular Pertussis			
Influenza			
Polio Vaccine			
Measles, Mumps and Rubella Vaccine			
Haemophilus Influenzae Type B Vaccine			
Hepatitis B			
Chicken Pox Vaccine			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
4. Appropriate Treatment of Children with Upper Respiratory Infection	NCQA	URI	5
5. Appropriate Testing for Children With Pharyngitis	NCQA	CWP	5
6. Depression Screening for Adolescent - Screening	NCQA	DSF-EA	5
Total			55

All claims-based measures are from NCQA HEDIS, and points are awarded in tiers based on national and peer benchmarks. No points will be awarded for Panels failing to meet the first tier of each measure, roughly the 25th percentile.

The Pediatric Clinical Quality Scorecard with tiered quality score benchmarks will be available in SearchLight. For 2026, four observational measures, Social Needs Screening, Depression Screening Follow Up, Optimal Asthma Control and Weight Assessment and Counseling for Nutrition and Physical Activity will be reported in Searchlight. No points will be attributed to these measures.

Panels must achieve at least 65% of the total clinical quality points to receive the full Participation Incentive and to be eligible for an OIA. This represents the 50th percentile in total Clinical Quality Scorecard points.

PCMH Clinical Quality Scorecard (Observation Measures—0 points)	Source
Social Needs Screening - Custom (SNS-SDOH)	CareFirst Custom Measure
Optimal Asthma Control (MIPS)	NCQA
Depression Screening for Adolescent - Follow Up (DSF-EB)	NCQA
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)	NCQA

Engagement Program Requirements

Engagement in the PCMH Program is a requirement for Participation Incentive and OIA eligibility. In PY2026, engagement will again be measured with a set of Panel, practice, and provider requirements. Failure to meet these requirements may results in the provider, practices, or Panel becoming ineligible to receive an OIA and/or retain the full Participation Incentive.

PCP Engagement Requirements include:

1. Each practice completes PCMH Practice Survey in Q1 of the Performance Year.
2. Each Panel identifies a Designated Provider Representative (DPR) who helps set Panel's expectations, co-leads PCMH discussion, and signs off on changes to Panel structure.
3. All PCMH providers in a practice complete CareFirst Health Equity Training by July 1, 2026. (more details below)

Care Management Expectations

While Care Management is no longer an engagement requirement for OIA eligibility, engagement with care coordination continues to be critical for success in the PCMH Program. CareFirst will continue to offer care coordination services for medical, behavioral health and social drivers of health (SDOH) support. This allows for more comprehensive care plans with access to home health, community resources and SDOH support programs.

Effective in 2024, referrals for any CareFirst Member (Commercial, Maryland Medicaid, Medicare Advantage and Dual-Eligible Special Needs) may be submitted via a single direct phone line (888-264-8648), secure email (**CareManagement@carefirst.com**) or through the referral link . Referrals can be made 24/7 via direct phone or secure email for any CareFirst Member, regardless of insurance policy. The referral should include the following information:

- Member name (first, last)
- Date of birth
- Member phone number
- CareFirst member ID
- Reason for referral
- Provider/office name and contact information for ongoing communication

A Care Management Coordinator will review the referral and match Members to the most appropriate suite of clinical support programs tailed to the patient's needs. The Care Management Triage team will acknowledge receipt of the referral and verify the Member benefit for Care Management. If the Member is not eligible, the triage team will notify the office/provider. If eligible, the Member will be assigned to the next

Measures	Panel Summary					Benchmarks				
						Not Tiered (No Points)	Tier 4 (50% Points)	Tier 3 (65% Points)	Tier 2 (80% Points)	Tier 1 (100% Points)
	Points Available	Points Obtained	# Members Compliant	# Members Opportunities	% Compliance	% COMPLIANCE TO ACHIEVE EACH TIER				
WELLNESS / PREVENTIVE CARE	**35**									
Well-Child Visits	15									
▪ Well-Child Visits in the First 15 Months of Life	5									
▪ Well-Child Visits for Age 15 Months-30 Months	5									
▪ Child and Adolescent Well-Care Visits	5									
▪ 3-11 years										
▪ 12-17 years										
▪ 18-21 years										
Immunizations for Adolescents-Combination 2	15									
▪ Tetnus, Diptheria Toxoids and Acellular Pertussis (TDAP/TD)										
▪ Meningococcal (MCV4)										
▪ Human Papillomavirus for Adolescents (HPV)										
Childhood Immunnizations—Combo 10	10									
Diphtheria, Tetanus and Acellular Pertussis										
Influenza										
Polio Vaccine										
Measles, Mumps and Rubella Vaccine										
Haemophilus Influenzae Type B Vaccine										
Hepatitis B										
Chicken Pox Vaccine										
Pneumococcal Conjugate										
Hepatitis A										
Rotavirus										
CARE OF ROUTINE CHILDHOOD ILLNESS	**10**									
Appropriate Treatment of Children with Upper Respiratory Infection	5									
Appropriate Testing for Children With Pharyngitis	5									
BEHAVIORAL HEALTH CARE	**5**									
Depression Screening for Adolescents-Screening	5									
Overall Clinical Score	55									
Overall Clinical Rate										

available Care Manager, who will make three attempts to connect with the Member over the following 14 days. When needed, a larger multidisciplinary team including a lead care manager, pharmacist, social worker and behavioral health care manager can be engaged to support social drivers of Health (SDOH), gaps in care, pharmacy, behavioral health, and follow-up appointments with PCP and specialists.

Confirmation of Care Management will occur, as well as communication from care teams through the duration of the care plan, including care plan activation, graduation and acute event follow-ups.

Health Equity Training

As racial and ethnic disparities in health continue to grow, CareFirst is committed to advancing health equity to all residents in the jurisdictions we serve. Patient-centered care must accommodate an increasingly diverse patient population. In 2026, all PCPs in PCMH Panels will be expected to complete one of the CareFirst Health Equity Trainings found online at the CareFirst Learning and Engagement Center: **carefirst.com/learning/health-equity/health-equity**.

As part of CareFirst's health equity strategy to reduce barriers to good health both in and out of clinical settings, CareFirst has created the "Understanding Implicit Bias" training course for providers. The course is offered free of charge to any clinicians contracted in all CareFirst networks and was recently recognized and approved by the Maryland Department of Health Office of Minority Health & Health Disparities for 2024. The course was created with the intent to further support the provider community, allowing them to use CareFirst training to apply for and renew their licensure in the state of Maryland as well as receiving Continuing Medical Education (CME) Credit.

Failure to complete the three engagement requirements detailed above will result in the practice becoming ineligible to receive an OIA and a reduction in Participation Incentive as described in Eligibility for Participation Incentive section of the PD&G.

Eligibility for Outcome Incentive Awards

The Pediatric PCMH Program pays substantial incentives to those Panels that demonstrate favorable outcomes and value for their Members. These incentives are called Outcome Incentive Awards (OIAs). All such incentives are expressed as add-ons to the professional fees paid to Pediatricians who comprise Panels who earn an OIA.

Practices must meet the conditions below to be eligible for an OIA:

1. The practice must be in a PCMH Panel that joined the Program on or before July 1st of the Performance Year. If the Panel joins after this date, it will not be eligible for an OIA until the following Performance Year.
2. The practice must be in a PCMH Panel that meets viability requirements by having at least 15,000 Member Months for the Performance Year.
3. The practice must be in a PCMH Panel that has a cost savings to budget in their Patient Care Account (i.e., Credits must exceed Debits).
4. The practice must be in a PCMH Panel that achieved a minimum of 65% of the quality points available (50th percentile compared to national benchmarks) on the Clinical Quality Scorecard.
5. The practice must meet all three engagement requirements.

OIAs are effective August 1 of the year following the Performance Year (e.g., August 1, 2026 for Performance Year 2025) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2027.). In order to be paid an OIA, the practice must participate in the PCMH Program throughout the incentive pay out period (August 1st - July 31st) following each Performance Year.

All OIAs earned by each practice are added on top of Base Fees and Participation Incentives.

OIAs are always calculated at the Panel level based on savings, quality score, Panel size, and date of Panel formation. Individual practices within a Panel will be ineligible for an OIA if any or all providers in the practice do not meet the four PCP Engagement Requirements. All other practices in a Panel that meet conditions one through five above will be eligible for an OIA.

For a Panel that joins the Program within the first six months of the Performance Year, any earned OIA will be prorated based on effective date of Panel's entry into the Program as shown below.

Proration of Outcome Incentive Award (OIA)

Effective Date	Prorated Percentage
1/1	100
2/1	92
3/1	83
4/1	75
5/1	67
6/1	58
7/1	50

OIAs and Participation Incentives will cease immediately upon termination of a practice's participation in the Program and/or termination of a Panel from the Program.

Outcome Incentive Award Calculation

The OIA is the intersection of cost savings to budget and PCMH Clinical Quality Scorecard results. The incentive awarded back to the Panel is designed to be roughly one third of the Panel's savings. Panels can achieve a higher OIA by earning a higher Clinical Quality Score, winning multiple years in a row, and having a larger Panel attribution. The OIA formulas are described below. Quality Score represents the Panels clinical attainment rate on the PCMH Clinical Quality Scorecard plus any improvement bonus points.

OIA Formulas Based on Panel Size and Win Years

Duration*	Average Members	Outcome Incentive Award
Pediatric Panels		
1	3,000+	Fee Increase = [(Quality Score + 30)/100] * 2.25 * % Savings
1	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 1.90 * % Savings
1	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 1.69 * % Savings
2	3,000+	Fee Increase = [(Quality Score + 30)/100] * 2.25 * %Savings * 1.10
2	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 1.90 * %Savings * 1.10
2	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 1.69 * %Savings * 1.10
3+	3,000+	Fee Increase = [(Quality Score + 30)/100] * 2.25 * %Savings * 1.20
3+	2,000-2,999	Fee Increase = [(Quality Score + 30)/100] * 1.90 * %Savings * 1.20
3+	1,250-1,999	Fee Increase = [(Quality Score + 30)/100] * 1.69 * %Savings * 1.20

Pediatric Quality OIA

Pediatric Panels can also be rewarded for providing high quality of care. Panels who achieve 80% on the Clinical Quality Scorecard and are no more than 5% overbudget will be awarded a 10-point OIA as long as all other OIA -eligibility criteria is met.

Eligibility for Participation Incentive

Participation Incentives are intended to fund the providers' time and attention to the Program and to assure frontline providers are properly informed of utilization, savings to budget and Quality Scorecard results necessary to drive transformation leading to better outcomes and value for the CareFirst population.

Practices can earn their 12 percentage point Participation Incentive by engaging in practice transformation and by sharing all PCMH utilization, budget, Quality Scorecard and OIA data with PCPs. Practices who do not complete the three PCP Engagement Requirements will lose all or portions of their Participation Incentive based on market size category as shown below. Panels that do not meet a minimum of 65% of the points available on the Clinical Quality Scorecard, and do not achieve a savings, will also lose all or portions of their Participation Incentive. Panels and practices that save compared to expected and meet PCP Engagement Requirements but fall below 65% on the Clinical Quality Scorecard will retain the full 12 percentage point Participation Incentive but will not be eligible for an OIA. Adjustments for practices losing all or part of the 12 points will go into effect in August of 2026 based on 2025 Performance.

Panels who fail to meet eligibility for the Participation Incentive two years in a row will risk the remaining six points, bringing the Participation Incentive to 0%, and will remain at 0% until engagement and Clinical Quality Scorecard minimums are met. Panels who lost all or a portion of the Participation Incentive are eligible to receive the full 12 percentage point Participation Incentive upon meeting all eligibility requirements in the next Performance Year.

Changes in Participation Incentive will be effective on August 1 of the year following the Performance Year (e.g., August 1, 2026, for Performance Year #15 – 2025) and remain in place for a full year until July 31 of the following year (e.g., July 31, 2027.)

Please note that any practices transitioning from PCMH to an Accountable Care Organization (ACO) may have their eligibility to retain their OIA and Participation Incentive. CareFirst recommends that you contact your Practice Consultant to determine any potential impacts before making any decisions.

Changes in Panel Composition

A variety of circumstances may arise over time that may impact provider membership of a Panel or practice. Panels or practices may dissolve, change their provider membership via attrition or termination, or allow Pediatricians to leave and join other Panels.

A Pediatrician may change Panels for any reason, including a change in their practice location or a change in their affiliation with a particular practice. In this case, the Pediatrician may join another Panel in the new location, or another practice that is part of Virtual Panel.

The following rules govern these Panel changes:

1. If a Panel's participation falls below five Pediatricians it must, within one year, increase its membership to five or more or the Panel will lose OIA eligibility for the Performance Year. If the Panel participation

falls below five Pediatricians for a full year, the Panel will be terminated from the Program. Exceptions may be granted with written request through Panel Governance.

2. A Panel may request an exception to the upper limit of 15 Pediatricians in writing. For an exception to be granted, the Panel must demonstrate that the Panel practices as a cohesive unit and must provide compelling justification as to why such larger size would not unduly diminish the contribution of each Pediatrician to overall Panel performance.
3. Multi-Panel Independent Group Practices and Multi-Panel Health Systems may choose to have an OIA paid at the entity wide tax identification number (TIN) level, notwithstanding the fact that all OIAs are determined at the Panel level as a Program requirement. In the situation, all Panels under the same TIN will receive a single OIA, determined by the weighted average of each Panel, weighted on size of Panel Debits.
4. If a new Pediatrician or practice joins an existing practice, the reimbursement level of the existing practice will be assumed by the new Pediatrician or practice, including the Participation Incentive and OIAs (if any), once the new Pediatrician has signed on to the PCMH Program. A new Pediatrician joining an existing practice will only be considered to be a member of the Panel on a prospective basis. No retroactive enrollment is allowed.
5. If a Pediatrician leaves a Panel but remains in the CareFirst HMO and RPN networks without participating in another Panel, the Pediatrician will lose the Participation Incentive and OIA at the point they terminate from the Panel.
6. If a Panel changes ownership or Tax ID, but the actual Pediatricians making up the Panel remain the same, the Panel will be treated as having continuous participation in the PCMH Program for the purposes of OIA and persistency awards.
7. Any practice that joins a Panel is required to be an active PCMH participant of that Panel during the last two complete calendar quarters of the current Performance Year to be eligible for an OIA. That is, only practices that actively participate in the Program by July 1 of the Performance Year are eligible for an OIA for that Performance Year. If a practice joins a Panel after July 1, that practice is excluded from the OIA for that Performance Year. A practice will be considered active in the Pediatric PCMH Program once the practice has signed both a Panel contract and the PCMH Addendum to their network agreement with CareFirst. A retroactive enrollment date is not allowed for practices that are new to PCMH.
8. Acceptance of a practice into an existing Panel requires unanimous agreement by the Panel, communicated in writing to CareFirst by the Panel's Designated Provider Representative (DPR).
9. If a practice leaves a Panel after the end of a Performance Year, joins another Panel and remains in good standing with the Program, the practice will keep the OIA earned in the previous Panel.

Appeals

Any Pediatrician or Panel as a whole may submit a letter to CareFirst requesting review of any aspect of the calculation of an OIA that they believe to be made in error. CareFirst will promptly (within two weeks) contact the Pediatrician and Panel to discuss the information submitted with the request as well as any other pertinent information. Following a thorough review, CareFirst will notify the appealing Pediatrician and/or Panel of its response in writing within 90 days of the receipt of complete information from the Pediatrician and/or Panel.

CareFirst will make corrections in Panel results if any errors are found. In carrying out corrections, CareFirst may provide a correction on a prospective basis or on a retrospective basis, depending on the circumstances of the particular case.

The deadline to submit an appeal for the 2025 Performance Year is September 1, 2026.

Signing on with PCMH

Participation in the Program is entirely voluntary. There is no penalty or negative impact on existing CareFirst fee payments for network RPN and HMO PCPs or practices who elect not to participate.

Each Pediatrician (or the practice to which they belong) will be required to sign an Addendum to its CareFirst RPN and HMO Participation Agreements.

If a Pediatrician applying for participation in the Program is in an established large group practice that contains more than 15 Pediatricians, the practice and CareFirst will agree on the way the practice will be divided into Panels prior to the effective date of Program participation.

If a Pediatric applicant is in a solo practice or a small practice and wishes to participate in the Program by joining another Panel(s) or practice(s) as part of a Virtual Panel, then all of the Pediatricians who would make up the Virtual Panel must sign a PCMH enrollment form indicating that they are voluntarily forming a Virtual Panel for the purposes of the Program and are attesting to their commitment to work individually and collectively toward Program goals. If a Virtual Panel is not formed, the practice will be added to a Collaborative Panel at CareFirst's sole discretion.

All Pediatricians within a practice who submit claims to CareFirst for payment under a single tax ID number must join so that all participate in the Program. Any division of the practice into Panels made for performance tracking purposes as described above does not affect this participation requirement.

Each practice must designate a lead provider or Staff member called a Practice Point of Contact to act as a primary point of contact between the Panel and CareFirst.

As stated above, practices receive formal PCMH Recognition by CareFirst immediately upon execution of the Participation Agreements, as defined by PCMH designation in the CareFirst Provider Directory.

Termination from PCMH

A practice may terminate its participation in the Program upon ninety (90) calendar days' prior written notice to CareFirst for any reason.

A Panel may terminate participation in the Program with ninety (90) calendar days' prior written notice to CareFirst for any reason. This will terminate all participants within such Panel from the Program unless they join another Panel. If a Pediatrician in a practice terminates participation in the Program, but does not terminate from the practice, the practice will be terminated from the Program. Notwithstanding this requirement, in the case of a Pediatrician who is recalcitrant with Program engagement, an individual Pediatrician may be terminated from the PCMH Program. Once the Pediatrician is terminated, they will no longer receive the participation fee or OIA.

A Virtual Panel may change its self-selected team of PCPs at any time if it continues to meet the minimum size requirements of the Program and notifies CareFirst. The consent of at least three-fifths (3/5) of the PCPs in the Virtual Panel is required to forcibly remove a practice from the Panel. A letter from the Panel's Designated Provider Representative is required to be sent to the practice that was voted to be removed informing them of the Panel's decision. A Collaborative Panel may not choose to remove any PCP from the Panel; however, CareFirst can remove PCPs whose lack of participation and cooperation with Panel goals is harming Panel performance.

CareFirst may immediately terminate a practice, Pediatrician and/or Panel from the Program under the following circumstances with written notice, unless the termination is related to the discontinuance of the entire Program (which requires 90 calendar days' prior written notice):

1. The practice, PCP and/or Panel repeatedly fails to comply with the terms and conditions of the Program.
2. The practice, PCP and/or Panel has substantial uncorrected quality of care issues.
3. Termination of either the Master Group Participation Agreement, or the Primary Care Physician Participation Agreement which terminates the Group's, Pediatrician's and/or Panel's participation in CareFirst's RPN or HMO networks.
4. Any other termination reason set forth in the termination provisions of the underlying Participation Agreements within the applicable notice periods set forth therein.

In a Collaborative Panel, as CareFirst will assign PCPs to these Panels, the PCPs of a Collaborative Panel may not decide to remove a PCP from the Panel. CareFirst may immediately terminate a practice or PCP that has been deemed by CareFirst to be detrimental to the success of the Collaborative Panel.

The payment of the Participation Fee and any OIA will immediately terminate upon the effective date of the Pediatrician's, Group's or Panel's termination from the Program, regardless of the reason for termination.

Disqualification of Participants

In the event that a CareFirst Pediatric PCMH practice does not meet the participant qualifications as defined above in the Panel Composition section of the Program Description and Guidelines, it must provide immediate notice to CareFirst whereupon the practice will be disqualified from participation in the Program. All PCMH -related financial incentives will cease for claims with dates of service on or after the Pediatrician's, Practice's, or Panel's termination date.

2026 Quality Provider Toolkit is coming soon.



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PRD1153-1E (1/26)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 4/15/2025)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

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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.