CareFirst
Family of health care plans

Vitality

MEMBER RESOURCE GUIDE 2022/2023

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Vitality is published annually by the Marketing Communications department of CareFirst BlueCross BlueShield (collectively, "CareFirst"). The articles in *Vitality* are not intended as medical advice. For your individual healthcare needs, you should consult with your doctor or nurse practitioner. 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 have a mailing address issue, call Member Services at the telephone number on the back of your member ID card.

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CAREFIRST IS PROUD TO BE RECOGNIZED AS ONE OF THE WORLD'S MOST ETHICAL COMPANIES 10-YEARS RUNNING!

WHAT'S INSIDE...

Stay Connected! Follow Us on Social Media:

BOK5101-9S (10/22)

Online Resources

MY ACCOUNT

For members of CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all corporate affiliates (collectively, "CareFirst"), *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
- And more

GET STARTED TODAY!

To set up your account, go to carefirst.com/myaccount and select *Register Now.*

CAREFIRST WELLBEING℠

NEW IN 2023! To help you find and maintain your sense of well-being in an increasingly complicated world, CareFirst is building a better wellness program. On January 1, 2023, we will launch CareFirst WellBeing—your personalized digital connection to your healthiest life and healthiest YOU.

The current Sharecare wellness program will transition to CareFirst WellBeing. The new site will feature all the tools, resources and support you rely on, but in a more precise and cohesive platform. Your profile data will carry over, too. Register with the new program using your Sharecare credentials on or after January 1. You can do this by downloading the CareFirst WellBeing app or visiting **carefirst.com/wellbeing** or *My Account*.

FIND A DOCTOR

Go to **carefirst.com/doctor** to begin. You can search for various providers, including specialists, mental or behavioral health, dental, and vision providers or healthcare facilities. Then, personalize your search to meet your needs 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*, when you use *Find a Doctor* to locate providers, you will automatically receive 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 member contract, 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 *Members,* then *Find Providers.*

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

CloseKnit™

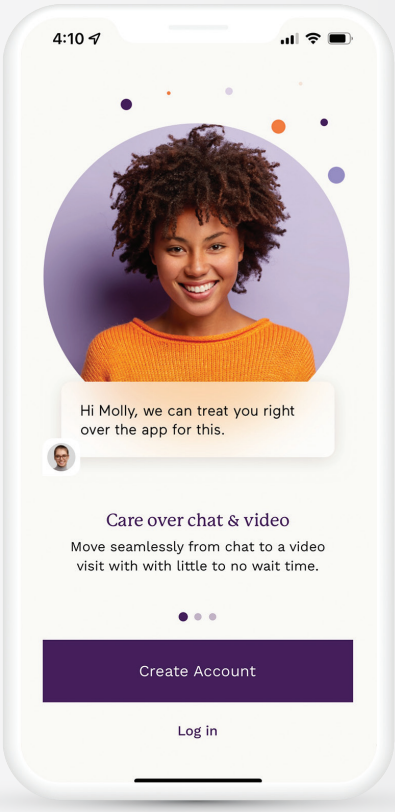
24/7 VIRTUAL-FIRST PRIMARY CARE

At CareFirst, we believe in high-quality, affordable and accessible healthcare. That's why we are encouraging CareFirst members age 18 or older to join CloseKnit.

CloseKnit is an advanced, virtual-first primary care practice available 24/7/365 through an easy-to-use app. You can chat with your dedicated Care Team at no cost, book appointments when it's most convenient for you, refill prescriptions, and receive preventive, urgent and chronic care, all from your mobile or tablet device. CloseKnit's Health Navigators can help you coordinate care with specialists, arrange for in-person care, answer benefits and billing questions, and more!

There are no fees to join CloseKnit and messaging with your Care Team is always free.

To learn more, visit
closeknithealth.com.



CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing telehealth services to CareFirst members.

OPTIONS FOR CARE

Establishing a relationship with a primary care provider (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	24/7	RX	VIRTUAL CARE	IN-PERSON CARE
CloseKnit Virtual Primary Care 24/7/365 virtual care for over 100 conditions through an easy-to-use app 18+ only	$	▪ Cough, cold and flu ▪ Urgent care needs ▪ Illness while traveling ▪ Therapy ▪ Medication questions ▪ Insurance or coverage questions ▪ In-the-moment consultation	✔	✔	✔	✔
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	✘	✔	✔	✔
Video Visit See a doctor 24/7 without an appointment for urgent care needs.	$$	▪ Cough, cold and flu ▪ Pink eye ▪ Ear pain	✔	✔	✔	✘
Convenience Care *(e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)* Health screenings, vaccinations, minor illness or injury	$$	▪ Cough and cold ▪ Pink eye ▪ Ear pain ▪ Flu shot	✘	✔	✘	✔
Urgent Care *(e.g., Patient First or ExpressCare)* 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 plans and HealthyBlue HMO, 2.0, Plus and Advantage plans

Outside the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia, benefits are available for emergency or urgent services. In addition, some plans provide out-of-network coverage for other covered services. Refer to your benefits guide for more information. BlueChoice Advantage and HealthyBlue Advantage plans provide in-network coverage for other covered services when a member uses the BlueCard PPO network; out-of-network coverage would apply when non-BlueCard providers perform those covered services.

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

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 telephone number on your member ID card and ask for the Away From Home Care coordinator.

For members with PPO, PPN and MPOS plans

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

When you arrive at the doctor's office or hospital, present your current CareFirst member ID card with the suitcase logo. 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 (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.

COMPLEX CARE MANAGEMENT

CareFirst's complex care management services provide an organized, comprehensive, holistic approach to your healthcare needs to reduce the frustration of fragmented care that those with complex care requirements often face. Your care manager can coordinate your medical care services and help you better understand your condition. Your care manager can also share resources to help you make informed decisions about your healthcare.

Complex care management services 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
- Empower you and your family members through education

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

Talk with your primary care provider (PCP) today to enroll in complex care management. You may also call CareFirst's team at 800-245-7013 and select the appropriate option.

ADVANCE DIRECTIVES

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

Doctors ask whether you will accept a treatment by discussing the risks and benefits and working with you to decide. But what if you can no longer make your own decisions? Anyone can wind up hurt or sick and unable to make decisions about medical treatments. An advance directive speaks for you if you are unable to, and it helps make sure your religious and personal beliefs will be respected. It is a useful legal document for adults of any age to plan for future healthcare needs.

While no one is required to have an advance directive, it is smart to think ahead and plan now. If you don't have an advance directive and later you can't speak for yourself, then usually your next of kin will make healthcare decisions for you. But even if you want your next of kin to make decisions for you, an advance directive can make things easier for your loved ones by helping to prevent misunderstandings or arguments about your care.

What can you do in an advance directive?

An advance directive allows you to decide who you want to make healthcare decisions for you if you are unable to do so yourself. You can also use it to say what kinds of treatments you do or do not want, especially the treatments often used in a medical emergency or near the end of a person's life.

Healthcare agent—The person you name to make decisions about your healthcare is called a "healthcare agent" (sometimes also called a "durable power of attorney for healthcare," but, unlike other powers of attorney, this is not about money). You can name a family member or someone else. This person has the authority to see that doctors and other healthcare providers give you the type of care you want, and they do not give you treatment against your wishes. Pick someone you trust to make these kinds of serious decisions and talk with this person to make sure they understand and are willing to accept this responsibility.

Healthcare instructions—You can let providers know what treatments you want to have or not have. (Sometimes, this is called a "living will," but it has nothing to do with an ordinary will about property.)

Examples of the types of treatment you might decide about include:

- Life support, such as breathing with a ventilator
- Efforts to revive a stopped heart or breathing (CPR)
- Feeding through tubes inserted into the body
- Medicine for pain relief

Ask your doctor for more information about these treatments. Think about how, if you become badly injured or seriously ill, treatments like these fit in with your goals, beliefs and values.

ADVANCE DIRECTIVES (continued)

How do you prepare an advance directive?

Begin by talking things over, if you want, with family members, close friends, your doctor or a religious advisor. Many people go to a lawyer to have an advance directive prepared. You can also get sample forms yourself from many places, including the organizations given as examples listed below. There is not one form that must be used. You can even make up your own advance directive document.

To make your advance directive valid, it must be signed by you in the presence of two witnesses, who will also sign the document. If you name a healthcare agent, make sure that person is not a witness. Maryland law does not require that the document be notarized. You should give a copy of your advance directive to your doctor, who will keep it in your medical file, and to others you trust to have it available when needed. Copies are just as valid as the originals.

You can also make a valid advance directive by talking with your doctor in front of a witness.

When would your advance directive take effect?

Usually, your advance directive would take effect when your doctor certifies in writing that you are not capable of making a decision about your care. If your advance directive contains healthcare instructions, they will take effect depending on your medical condition at the time. If you name a healthcare agent, you should make it clear in the advance directive when you want the agent to be able to make decisions for you.

Can you change your advance directive?

Yes, you can change or take back your advance directive at any time. The most recent one will count.

Where can I get an advance directive?

Visit **https://theconversationproject.org/nhdd/advance-care-planning/** for your state's form and additional resources.

Where can I learn more?

Information about CareFirst's hospice and palliative care programs can be found at **carefirst.com/hospice** and **carefirst.com/palliative**.

Where can you get forms and more information about advance directives?

There are many places to get forms, including medical, religious, aging and legal organizations. Listed below are three examples of where you can get advance directive forms. Any of these forms are valid in Maryland, but not all may be in keeping with your beliefs and values. Your advance directive does not have to be on any particular form.

- **Maryland Attorney General's Office**
  410-576-6300 or 888-743-0023
  https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx
- **MyDirectives**
  info@MyDirectives.com
  https://mydirectives.com/
- **CRISP Health**
  877-952-7477
  https://www.crisphealth.org

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 primary care provider (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
- Or for 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.

Referrals for members in HMO plans

Access to 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

The prescription drugs covered on the CareFirst formulary (drug list) 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 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.

DRUG TIER (COST SHARE)	COST	DEFINITION
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?

Log in to *My Account* and view the *Drug and Pharmacy Resources* section, check your enrollment materials or call the Pharmacy telephone number on the back of your member ID card.

For a printed copy of your drug list or to find out more about prescription guidelines, call the pharmacy department at 877-800-3086.

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 guidelines

To ensure you are receiving the most appropriate medication for your condition(s), certain medications have prescription guidelines. These may include:

- **Prior authorization** is 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.

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 and 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 primary care provider (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 your Evidence of Coverage or the benefits guide 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. To help you remember the conversation and avoid having to call Member Services again, write down:
  - The date and time you called,
  - The name of the Member Services representative,
  - What course of action the Member Services representative will take, and
  - When you can expect resolution, if applicable.

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 benefits 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 in two ways, by mail or online.

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.

Submit your claim form online

CareFirst also offers online claims submission for medical, dental and mental or behavioral health 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.

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:

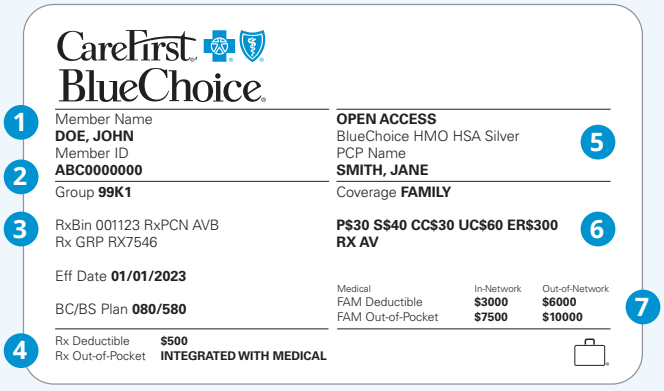
- Call Member Services at the telephone number on the back of your member ID card. If you have trouble understanding English, please tell the representative, and we will have an interpreter who speaks your preferred language join the call.
- Send an email to **quality.care.complaints@carefirst.com**

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 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 to route claims for payment

4 Prescription deductible and out-of-pocket maximums

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

6 Copay amounts—abbreviations correspond to your plan copays:
P=primary care provider
S=specialist
CC=convenience care
UC=urgent care
ER=emergency room
RX=drug
AV=adult vision

7 Medical deductible and out-of-pocket maximums

NOTICE OF PRIVACY PRACTICES

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, "CareFirst") are 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 rights:

- Request a copy of your protected health information that is contained in a designated record set pertaining to your medical record.
- Request that we restrict the protected health information we use or disclose about you for payment or healthcare operations.
- Request 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.
- Request that we amend your information if you believe your protected health information is incorrect or incomplete.
- Request an accounting of disclosures of your protected health information for reasons other than payment or healthcare operations.

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, please call the CareFirst Privacy Office at 800-853-9236.

- Fax a written complaint to 301-470-5866.
- Mail a written complaint to:
  CareFirst BlueCross BlueShield
  Quality of Care Department
  Clinical Appeals Unit
  P.O. Box 17636
  Baltimore, MD 21298-9375

Please include your name, address, member ID number, telephone number and as much detail as possible about the event or incident, including the date(s) of service. We respond to all complaints or letters of concern within 60 days (or sooner), depending on the urgency of the situation.

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.

NOTICE OF INFORMATION SHARING TO ENHANCE OR COORDINATE YOUR CARE (continued)

- 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.
- 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 separately 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

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 evaluate new and existing technologies for medical and mental or behavioral health procedures, medications and devices through a formal review process. CareFirst clinicians and researchers consider input from medical professionals in the community, government agencies and published scientific studies. Existing technologies are reviewed bi-annually.

WE'RE HERE FOR YOU

As a CareFirst member, you have access to providers and resources if you or a loved one is living with a mental health condition or substance use disorder. Our support team is made up of specially trained service representatives, registered nurses and licensed behavioral health clinicians ready to help.

If you or someone you know is in crisis, contact the CareFirst support line at 800-245-7013 or dial 988.

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 Evidence of Coverage 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 Evidence of Coverage to determine whether you are eligible for these surgical procedure benefits.

NOTICE: MEMBER COVERAGE AND RATE INFORMATION (continued)

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 guide or Evidence of Coverage 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 online at **www.mdinsurance.state.md.us** 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 ten 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 Evidence of Coverage to determine whether you are eligible for these surgical procedure benefits.

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 **www.mdinsurance.state.md.us**.

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.

Please 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.

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 NONDISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	civilrightscoordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

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

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

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

Foreign Language Assistance

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

አማርኛ(Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǘá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɛ́ nì ɓídɖí-wùdù mú ɓɛ́ m̀ ké se wídɖí dɔ̀ pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɖá fǘùn-nɔ̀ɓà nìà dɛ́ waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdɖàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓɛ́ ɔ ké nì wuduɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.

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