

Retiree Health Benefit Options

BlueChoice Advantage Plans

MONTGOMERY COUNTY GOVERNMENT

Contents

Your BlueChoice Advantage Retiree Health Plans 1

BlueCard & Blue Cross Blue Shield Global® Core. . 3

What Medicare Does and Doesn't Cover 5

How to File Medical Claims 6

Words You Need to Know 7

BlueChoice Advantage POS Network Summary of Benefits 8

CareFirst WellBeing 11

Manage Your Healthcare with My Account 13

Rights and Responsibilities 15

Notice of Nondiscrimination and Availability of Language Assistance Services 19

BlueChoice Advantage Plans brochure for Retirees and their dependents eligible for Medicare.

Your BlueChoice Advantage Retiree Health Plans

Your protection against illness and high medical costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Montgomery County Government has selected CareFirst BlueCross BlueShield plans for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare-covered services. That way, you can just concentrate on feeling better.

This benefit summary will show you how to use your benefits. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the *Words You Need to Know* section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the plans are and how they work.
- What Medicare does and doesn't cover.
- When you'll need to file claims, and how to file them.
- How to get the most from your health care plans.
- What your benefits are.

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at 888-417-8385. You can call between 8:00 a.m. and 9:00 p.m., Monday through Friday. A customer service representative will be happy to help you.

Plan choices

- BlueChoice Advantage High Option
- BlueChoice Advantage Standard Option

General plan differences

	BlueChoice Advantage High Option	BlueChoice Advantage Standard Option
Medical Copays	$10 PCP $10 Specialist	$15 PCP $30 Specialist
Emergency Room Copay	$25	$35
Out-of-Pocket Maximum	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 Family

If it is a Medicare covered service, CareFirst will cover it. We will not apply our contract exclusions for services that Medicare approved and covered. We will reimburse the Medicare deductible and the 20% coinsurance at 100% for all Medicare covered services.

* These benefits are based on in-network benefits.

This is a summary of your benefits. For complete descriptions, please see the benefits contract.

SUM1816-1P (8/19)_C

What your plan is and how it works

How do the plans work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare — covered services. Your CareFirst Medicare Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare—covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as "accepting assignment."

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services.

How can I save money with my plan?

Your plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts, regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

Getting the most from your health care plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

1. Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.
2. Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services.
3. Always give your Medicare membership number and your CareFirst membership number when you receive care.
4. If you need to file a claim, file right away so that you don't miss the filing deadline.



BlueCard & Blue Cross Blue Shield Global® Core

Wherever you go, your health care coverage goes with you

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

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

When you're outside the CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. service area (Maryland, Washington, D.C. and Northern Virginia), you can use the local Blue Cross Blue Shield Plan and their negotiated rates with doctors and hospitals. You won't pay more than these rates, and you shouldn't need to complete claim forms or pay up front for care—except for standard out-of-pocket expenses like deductibles, copayments and coinsurance.



In an emergency, always go directly to the nearest hospital.

Within the U.S.

1. Always carry your member ID card for easy access to care.
2. To find nearby doctors and hospitals, visit the National Doctor and Hospital Finder at bcbsglobalcore.com or call BlueCard Access at 800-810-BLUE (2583).
3. Call the Customer Service number on your member ID card to verify benefits or check if pre-certification or prior authorization is needed.
4. Present your ID card when you arrive at a participating doctor's office or hospital.
5. After your visit, you shouldn't need to complete claim forms, except for your usual out-of-pocket expenses. CareFirst will send you a complete explanation of benefits.

Using your coverage worldwide

Just like your passport, always carry your member ID card when you travel or live outside the U.S. The Blue Cross Blue Shield Global® Core program provides medical assistance and access to care worldwide. The process is similar to using your coverage in the U.S., with a few exceptions:

At hospitals in the BCBS Global Core Network, you usually won't pay up front for inpatient care. You're responsible for standard out-of-pocket expenses, and the hospital should submit your claim.

At hospitals outside the BCBS Global Core Network, you pay for care up front, then complete an international claim form and send it to the BCBS Global Core Service Center. Find the form at bcbsglobalcore.com.

To find a BlueCard provider outside the U.S., visit bcbsglobalcore.com.

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

Medical assistance when outside the U.S.

Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24/7, for help finding doctors, hospitals or other healthcare professionals, or to receive medical assistance. A coordinator, working with a medical professional, can help you make an appointment or arrange hospitalization if needed.



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

What Medicare Does and Doesn't Cover

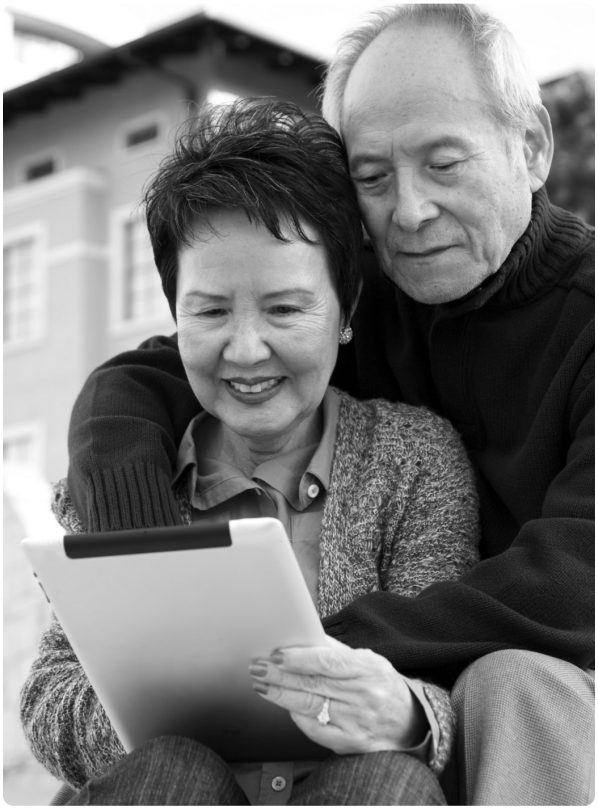
What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary:

- Inpatient hospital facility charges.
- Care in a skilled nursing facility after a hospital stay.
- Home health care provided by a Medicare—participating home health agency.
- Hospice care for the terminally ill.

Medicare Part B (medical services insurance) partially pays for medically necessary:

- Physician's services.
- Outpatient hospital services.
- Home health visits.
- Physical and speech therapy.
- Services and supplies covered by Medicare, such as x-rays and durable medical equipment.



What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

How to File Medical Claims

For care rendered in Maryland:

- If the provider accepts Medicare assignment, Medicare and CareFirst payments are sent directly to the provider.
- If provider does NOT accept Medicare assignment, the Medicare and CareFirst payments are sent directly to you.
- You will receive:
  - ☐ Medicare Explanation of Benefits
  - ☐ Carefirst Explanation of Health Care Benefits

Provider will file claim to Medicare Part A or B for processing



Claim is automatically forwarded to CareFirst BlueCross BlueShield for eligible supplemental payments

For care rendered outside of Maryland:

- If the provider has signed an agreement with Medicare to accept assignment, the provider will be paid directly. If the provider does not accept Medicare assignment you will be paid directly and the provider will send you a bill.
- The BlueCard® program was developed to automatically process all of your out-of-area claims. This means you will no longer have to submit any claims to CareFirst for your Medicare Supplemental benefits. The provider will submit the claims for you.
- If the provider does not accept Medicare assignment, you may be asked to pay the full amount of the bill (up to 15% over Medicare's approved amount) at the time of service. The Medicare and CareFirst payments are sent directly to you.
- Once the claim is processed by Medicare, you will receive a Medicare Explanation of Benefits.
- Once the supplemental benefit is paid by CareFirst, you will receive a CareFirst Explanation of Health Benefits with the payment.

Provider will file claim to Medicare Part A or B for processing



Claim is automatically forwarded to CareFirst for eligible supplemental payments

Words You Need to Know

Approved amount

The amount that Medicare allows participating providers to be paid for Medicare-covered services. Payments are made according to the Medicare fee schedule. Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".

Coinsurance

Some services require that you pay a percentage of the costs for your medical care.

Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days.

Your plan pays the Part A coinsurance for you.

Deductibles

Some services require that you pay a deductible before Medicare begins to pay.

Limiting charge

Some providers do not accept the Medicare approved amount as payment in full for Medicare-covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you. The limiting charge does not apply to any of the Traditional Medicare Supplemental Plan benefits that Medicare does not cover.

Medicare fee schedule

In general, payments for services are made according to the standard Medicare-approved fee schedule.

Medicare participating provider

Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.

Medicare non-participating provider

Other physicians and suppliers who do not agree to always accept the Medicare Non-Participating approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare-covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.

Provider

Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

BlueChoice Advantage POS Network Summary of Benefits

Plan Features	HIGH OPTION		STANDARD OPTION	
	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]
When members turn 65 years old or have Medicare due to a disability, Medicare will become primary. If it is a Medicare covered service, CareFirst will cover it. CareFirst will not apply the contract exclusions for services that Medicare approved and covered. CareFirst will reimburse the Medicare deductible and the 20% coinsurance at 100% for all Medicare covered services. If the claim is non-assigned additional benefits may be provided up to the Medicare Maximum Limiting Charge. Members will not be responsible for in-network copays.				
Provider Network	Visit **carefirst.com/mcg** to locate providers			
24-HOUR NURSE ADVICE LINE—FREE ADVICE FROM A REGISTERED NURSE				
Visit **carefirst.com/mcg** to learn more about your options for care.	When your doctor is not available, call 800-535-9700 to speak with a registered nurse about your health questions and treatment options.			
ANNUAL DEDUCTIBLE (BENEFIT PERIOD)[4]				
Individual	None	$300	None	$300
Family	None	$600	None	$600
ANNUAL OUT-OF-POCKET MAXIMUM (BENEFIT PERIOD)[5]				
Medical	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family
LIFETIME MAXIMUM BENEFIT				
Lifetime Maximum	None	None	None	None
PREVENTIVE SERVICES				
Well-Child Care (including exams & immunizations)	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Breast Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Pap Test**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Prostate Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Colorectal Cancer Screening**	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING				
Office Visits for Illness	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[7]	No charge*	No charge*	No charge*	No charge*
Lab[6] (at approved locations)	No charge*	No charge*	No charge*	No charge*
X-ray[6] (at approved locations)	No charge*	No charge*	No charge*	No charge*
Allergy Shots	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Physical, Speech and Occupational Therapy (limited to 90 visits/injury/benefit period)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Chiropractic	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Acupuncture	$10 per visit	Dedutible, then 20% of Allowed Benefit	$30 per visit	Deductible, then 20% of Allowed Benefit

BlueChoice Advantage POS Network Summary of Benefits

Plan Features	HIGH OPTION		STANDARD OPTION	
	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]
EMERGENCY SERVICES				
Urgent Care Center	No charge*	No charge*	No charge*	No charge*
Emergency Room—Facility Services	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)	$35 per visit (waived if admitted)	$35 per visit (waived if admitted)
Ambulance (if medically necessary)	No charge*	No charge*	No charge*	No charge*
HOSPITALIZATION (MEMBERS ARE RESPONSIBLE FOR APPLICABLE PHYSICIAN AND FACILITY FEES)				
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES				
Home Health Care (90-visit maximum in-network)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	No charge*	No charge*	No charge*	No charge*
Skilled Nursing Facility (limited to 100 days/benefit period)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
MATERNITY				
Preventive Prenatal and Postnatal Office Visits	$10 per visit	Deductible, then 20% of Allowed Benefit	$30 per visit	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7] (limited to 6 attempts per live birth)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
In Vitro Fertilization Procedures[7] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for applicable physician and facility fees)				
Inpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge* after $150 per admission	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	No charge*	Deductible, then 20% of Allowed Benefit	No charge*	Deductible, then 20% of Allowed Benefit
Office Visits	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit
Medication Management	$10 per visit	Deductible, then 20% of Allowed Benefit	$15 per visit	Deductible, then 20% of Allowed Benefit

BlueChoice Advantage POS Network Summary of Benefits

Plan Features	HIGH OPTION		STANDARD OPTION	
	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]	In-Network Benefits Cost to Member[1,2]	Out-of-Network Benefits Cost to Member[1,3]
MEDICAL DEVICES AND SUPPLIES				
Durable Medical Equipment	No charge*	No charge*	No charge*	No charge*
Hearing Aids for ages 0–18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*	No charge*	No charge*	No charge*
Adult Hearing Screenings and Hearing Aids	Blue365 members receive a complimentary hearing screening and discounted prices on hearing aids.			

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.
** Copay applies if office visit is not billed.
1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
3 Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
4 For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
5 For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.
6 If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.
7 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

Manage Your Healthcare with My Account

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

Scan the QR code or visit carefirst.com/myaccount to register.

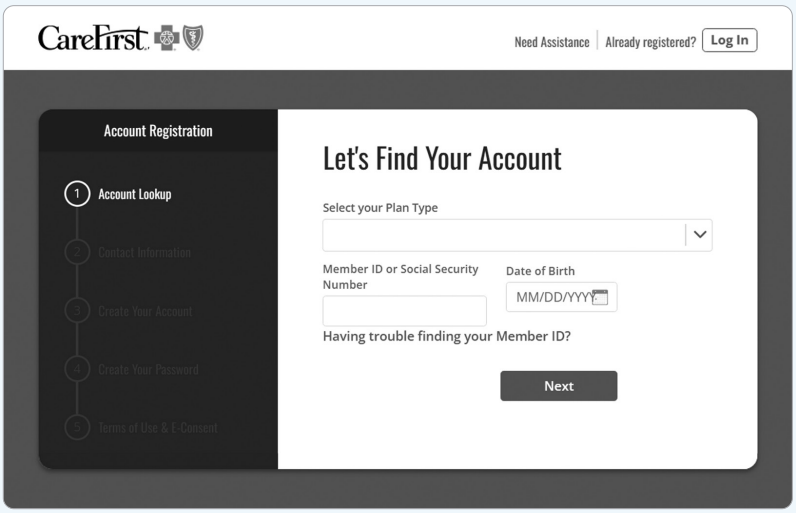
Get started

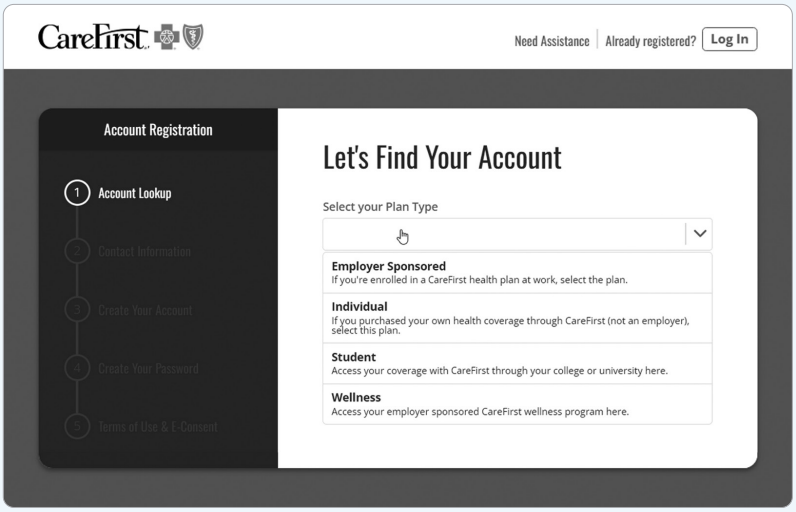
Members 12 years of age and older may register for My Account. Have your member ID or, the last four digits of your social security number. Signing up is easy and only takes a few minutes.

Complete a few more steps and you're ready to access your personalized member portal.

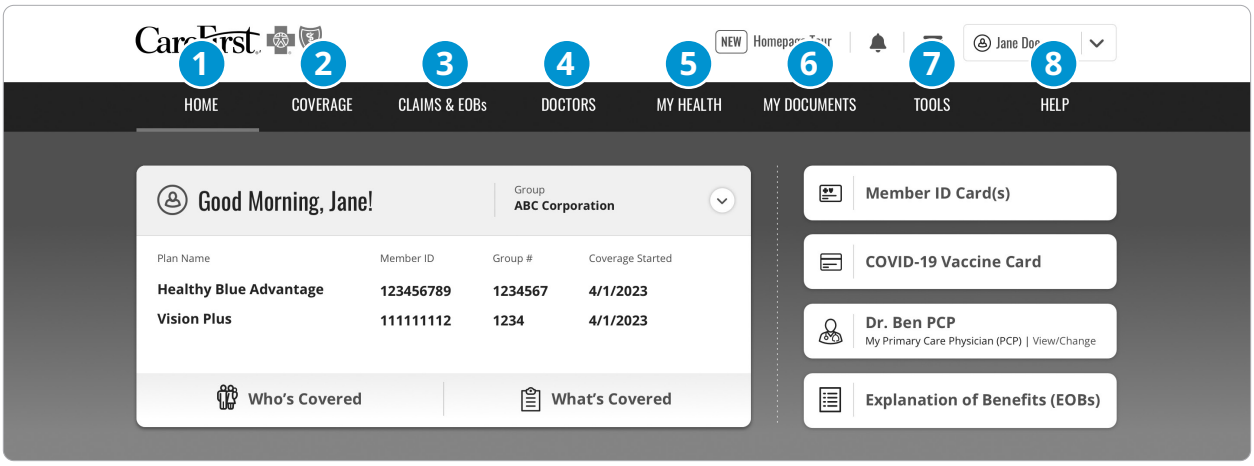
Already registered?

Explore the features My Account offers on the next page.





Manage Your Healthcare with My Account



My Account at a glance

1 Home

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

2 Coverage

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

3 Claims & EOBs

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

4 Doctors

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

5 My Health

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

6 My Documents

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

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures[3]

8 Help

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

[1] Only if offered by your plan.

[2] Only available when using a computer.

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

SUM6858-1N (7/24)

Rights and Responsibilities

Notice of privacy practices

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, CareFirst) are committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain a copy of our Notice of Privacy Practices, go to **carefirst.com/mcg** and click on *Privacy Statement* at the bottom of the page, click on *Health Information* then click on *Notice of Privacy Practices.* 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 their Notice of Privacy Practices. If you don't know whether your employer is self-insured, please contact your Human Resources department.

Member satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.

CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - Send an email to: **quality.care.complaints@carefirst.com**
  - Fax a written complaint to: **301-470-5866**
  - Write to:
    CareFirst BlueCross BlueShield
    Quality of Care Department
    P.O. Box 17636
    Baltimore, MD 21297

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

These procedures are also outlined in your Evidence of Coverage.

If you wish, you may also contact the appropriate jurisdiction's regulatory department regarding your concern:

VIRGINIA:
Complaint Intake, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Richmond, VA 23233-1463
Phone #: 800-955-1819 or 804-367-2106
Fax #: 804-527-4503

Office of the Managed Care Ombudsman, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218
Phone #: 1-877-310-6560 or 804-371-9032

DISTRICT OF COLUMBIA:
Department of Insurance, Securities and Banking, 801 1st Street, NE, Suite 701, Washington, DC 20002
Phone #: 202-727-8000

MARYLAND:
Maryland Insurance Administration, Inquiry and Investigation, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202
Phone #: 800-492-6116 or 410-468-2244

Office of Health Care Quality, Spring Grove Center,
Bland-Bryant Building, 55 Wade Avenue, Catonsville, MD 21228
Phone #: 410-402-8016 or 877-402-8218

For assistance in resolving a Billing or Payment Dispute with the Health Plan or a Health Care Provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:

Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202
Phone #: 410-528-1840 or 877-261-8807
Fax #: 410-576-6571
web site: www.oag.state.md.us

Hearing impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: 800-735-2258
National Capital Area TTY: 202-479-3546
Please have your Member Services number ready.

Language assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Please Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of subscriber/ member information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use

and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care 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 PHI may endanger you.
- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at 800-853-9236 or send an email to privacy.office@carefirst.com.

Members' rights and responsibilities statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible individuals' rights statement wellness and health promotion services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.

Habilitative services

CareFirst provides coverage for habilitative services to members younger than the age of 19. This includes habilitative services to treat congenital or genetic birth defects, including a defect existing at or from birth, a hereditary defect, autism or an autism spectrum disorder, and cerebral palsy.

Habilitative services include speech, physical and occupational therapies. CareFirst must pre-approve all habilitative services. Any deductibles, copayments and coinsurance required under your contract apply. Policy maximums and benefit limits apply. Habilitative services are not counted toward any visit maximum for therapy services.

Please note that any therapies provided through the school system are not covered by this benefit. This coverage applies only to contracts sold to businesses based in Maryland. Check your contract coverage to determine if you are eligible to receive these benefits. If you have questions regarding any of these services, contact Member Services at the telephone number on your member ID card.

Mastectomy-related services

CareFirst provides coverage for home visits to members who undergo a mastectomy (the surgical removal of all or part of the breast as a result of breast cancer) or the surgical removal of a testicle. Coverage includes one home visit that occurs 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 less than 48 hours or have the procedure performed on an outpatient basis. This coverage applies only to contracts sold to businesses based in Maryland. Please check your contract coverage to determine if you are eligible for these surgical procedure benefits.

CareFirst offers other benefits for mastectomy-related services, 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 Benefit Guide or Evidence of Coverage for more details or call Member Services at the telephone number on 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.

CUT6623-1P (8/17)_C

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Foreign Language Assistance

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

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

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

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

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

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

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

Notice of Nondiscrimination and Availability of Language Assistance Services

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

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fûà-fǔá-tìǐn nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jéɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mɔ́ m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé ɖé nì ɓíɖí-wùdù mú ɓɛ́ m̀ ké se wíɖí ɖò péɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fǔùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwè. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jǔǐn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nììn ɓé ɔ ké nì wuɖuɔ̀ mú zà.

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

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

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

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

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

Notice of Nondiscrimination and Availability of Language Assistance Services

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

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

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

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

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

Health benefits administered by:

CareFirst

Family of health care plans

CONNECT WITH US:

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

CST6441-1N (9/26)