BluePreferred PPO Gold 1000 Summary of Benefits

Non-Integrated Deductible

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLNESS PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/sharecare** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[2,3]		
Individual/Family	$1,000 Individual/$2,000 Family (separate)	$2,000 Individual/$4,000 Family (separate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,4,5]		
Individual/Family	$4,000 Individual/$8,000 Family (separate)	$8,000 Individual/$16,000 Family (separate)
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge*
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[6]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	Deductible, then $50 per visit	Deductible, then $150 per visit
Office Visits for Illness—PCP[6,7]	$15 per visit	Deductible, then $50 per visit
Office Visits for Illness—Specialist[6,7]	$30 per visit	Deductible, then $50 per visit
Allergy Testing[6]	$30 per visit	Deductible, then $50 per visit
Allergy Shots[6]	$30 per visit	Deductible, then $50 per visit
Physical, Speech, and Occupational Therapy[6]	$30 per visit	Deductible, then $50 per visit
Chiropractic[6]	$30 per visit	Deductible, then $50 per visit
Acupuncture[6]	Not covered	Not covered
IMMEDIATE AND EMERGENCY SERVICES		
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	$15 per visit	Deductible, then $50 per visit
Urgent Care Center[8] (such as Patient First or ExpressCare)	$50 per visit	$50 per visit
Hospital Emergency Room Services[8]		
■ Facility	Deductible, then $250 per visit (waived if admitted)	In-network deductible, then $250 per visit (waived if admitted)
■ Physician	Deductible, then $30 per visit	In-network deductible, then $30 per visit
Ambulance (if medically necessary)[8]	Deductible, then $30 per service	In-network deductible, then $30 per service

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Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
DIAGNOSTIC SERVICES		
Labs		
■ Non-Hospital/Freestanding Facility	$15 per visit	Deductible, then $65 per visit
■ Hospital	Deductible, then $30 per visit	Deductible, then $110 per visit
X-ray		
■ Non-Hospital/Freestanding Facility	$30 per visit	Deductible, then $80 per visit
■ Hospital	Deductible, then $60 per visit	Deductible, then $110 per visit
Imaging		
■ Non-Hospital/Freestanding Facility	$200 per visit	Deductible, then $250 per visit
■ Hospital	Deductible, then $400 per visit	Deductible, then $450 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgery (Non-Hospital)		
■ Facility	$200 per visit	Deductible, then $300 per visit
■ Physician	$30 per visit	Deductible, then $50 per visit
Outpatient Surgery (Hospital)		
■ Facility	Deductible, then $300 per visit	Deductible, then $400 per visit
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit
Inpatient Surgery and Hospital Services		
■ Facility	Deductible, then $400 per admission	Deductible, then $500 per admission
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge*	Deductible, then $50 per visit
Hospice (Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period)	No charge*	Deductible, then $50 per visit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then $30 per admission	Deductible, then $50 per admission
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $50 per visit
Delivery and Facility Services	Deductible, then $400 per admission	Deductible, then $500 per admission
Artificial and Intrauterine Insemination[6,9]	Not covered	Not covered
In Vitro Fertilization Procedures[6,9]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	$15 per visit	Deductible, then $50 per visit
Outpatient Services		
■ Facility	$50 per visit	Deductible, then $50 per visit
■ Physician	$30 per visit	Deductible, then $50 per visit
Inpatient Services		
■ Facility	Deductible, then $400 per admission	Deductible, then $500 per admission
■ Physician	Deductible, then $30 per visit	Deductible, then $50 per visit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids	Not covered	Not covered

BluePreferred PPO Gold 1000 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
PRESCRIPTION DRUGS[10,11]		
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List	
Annual Prescription Drug Deductible	$250 per person (waived for generic drugs)	
Preventive Drugs	No charge*	
Oral Chemo Drugs and Diabetic Supplies	No charge*	
Generic Drugs	30-day supply $10; 90-day supply $20 (maintenance drugs only)	
Preferred Brand Drugs[12]	30-day supply Deductible, then $45; 90-day supply Deductible, then $90 (maintenance drugs only)	
Non-preferred Brand Drugs[13]	30-day supply Deductible, then $65; 90-day supply Deductible, then $130 (maintenance drugs only)	
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $100 maximum; 90-day supply Deductible, then 50% up to $200 maximum (maintenance drugs only)	
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $150 maximum; 90-day supply Deductible, then 50% up to $300 maximum (maintenance drugs only)	
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)		
Annual Dental Deductible	$25	$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	No charge*	20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

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Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3 Separate - 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.
4 Separate - 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. The out-of-pocket maximum includes deductibles, copays and coinsurance.
5 All drug costs are subject to the in-network out-of-pocket maximum.
6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
9 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options forinfertility. Preauthorization required.
10 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
11 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
12 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
13 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

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

The benefits described are issued under form numbers: DC/CF/SHOP/GC (R 1/19) • DC/CF/SHOP/PPO/EOC (1/17) • DC/GHMSI/DOL APPEAL (R. 1/17) • DC/CF/SHOP/PPO/DOCS (1/17) • DC/CF/BP PPO/1000 90-70 (1/19) • DC/CF/BP PPO BF HSA/SIL 1500 (1/19) • DC/CF/BP PPO CDH/2000 80-60 (1/19) • DC/CF/BP PPO CDH/SIL 1500 (1/19) • DC/CF/BP PPO CDH/SIL 2000 (1/19) • DC/CF/BP PPO/GOLD 500 (1/19) • DC/CF/BP PPO/GOLD 1000 (1/19) • DC/CF/BP PPO/GOLD 1500 (1/19) • DC/CF/BP PPO/PLAT 0 (1/19) • DC/CF/BP PPO/PLAT 500 (1/19) • DC/CF/BP PPO/SIL 1000 (1/19) • DC/CF/BLCRD (R. 6/18) • DC/CF/MEM/BLCRD (R. 6/18) • DC/CF/ANCILLARY AMEND (10/12) • DC/CF/SHOP/ELIG AMEND (1/17) • DC/CF/SHOP/2019 AMEND (1/19) • DC/CF/SG/CCHRADM (1/19) • DC/CF/PT PROTECT (9/10) • DC/GHMSI/HEALTH GUARANTEE 6/18 • DC/CF/SG/INCENT (R. 1/19) • DC/CF/SHOP/ELIG (1/14) and any amendments.

CareFirst

SUM4403-1P (9/18) ■ DC ■ 2019 2-50 ACA Compliant (Can be sold as HRA)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

Foreign Language Assistance

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

አማርኛ (Amharic) **ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።**

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

ततथयिों का उल्लेख ी और आपके ललए ककसी तनयत समय-सीमा के भीतर काम करना ज़रूरी ी। आपको यजिानकारीऔर सबथं ति सयिता अपनी भाषा में तनःशिल्क पाने का अथकिार ै। सदस्यों को अपने पचिान पत्र के पीछे हदए गए फोननबर पर कॉल करना चाहएि। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते ैं और जब तक 0 दबाने के ललए न कि जाए, तब तक सवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर हदया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fù à-fṹá-fĩ̀in nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwɛ̀ 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-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fũ̀ùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖɛ́ĩn nyɛ. Nyɔ tɔ̀ɔ sɛ́ĩn mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàɖàïn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jʉ̃ĩn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nĩ̀in ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাাংলা (Bengali) লক্ষ্য করুন: এই ননাটশি আপনার ববমা কভাশরজ সম্পশক তথ্য রশশে। এর মশযয গুরুত্বপূর্ তাবরখ থ্াকশত পাশর এবাং বনবদ ষ্ট তাবরশখর মশযয আপনাশক পদশক্ষ্প বনশত হশত পাশর। ববনা খরশ বনশজর ভাষা এই তথ্য পাওোর এবাং সহাতো পাওোর অবযকার আপনার আশ। সদসযশদরশক তাশদর পবরপেশরে বপশেন থ্াকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টপিশত না বলা পর্ন্ত অশপক্ষ্া করশত পাশরন। র্খন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলনু এবাং আপনাশক নদাভাষীর সশ সাংরুক্ত করা হশব।

اردو *(Urdu)* توجہ : یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے- اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکنہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے- آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہکیے 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 دیگرلوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں- ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبانبتائیں 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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 855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Dine Bizaad *(Navajo)* Ge': Dif bee it hane'igif bii' dahǫ́áQ bee eedahǫ́zin beeso ach' h naanil nik'ist'i'fgii ba. Bii' dahǫ́áQQ doo fiyisif yoolkaaligif dǫ́ǫ́ t'aadoo le'e adadoolyłiligii da yǫ́keedgo t'aa doo bee e'e'aahi ajiil'łih. Bee na ahǫ́ǫ́t'i' dii bee it hane' dǫ́ǫ́ nika'adoowot t'aa nfnizaad bee t'aa jiik'e. Atah danilinigif beesh bee hane'e bee wǫ́tta'igif nitt'izgo bee nee hǫ́dolzinfgif bikeed , bikaa' bich'l' hodoonihjʃ́'. Aadǫ́ǫ́ naanata' ef kojl' dahǫ́doolnih įǫ́ǫ́ǫ̨ǫ́ǫ̨ǫ́ǫ́ǫ́ǫ́ǫ́ą́ dǫ́ǫ́ yii diitts'llt yattł'łgif t'aa nflefjʃ́ aadǫ́ǫ́ ef bikee'dǫ́ǫ́ naasbc;ác;ás bit adidiilchit. Aka'anidaalwǫ́'fgif neidiit go, saad bee yanitt'i'fgif yii diikit dǫ́ǫ́ ata' halne'e la nfka'adoolwot.

HealthyBlue PPO HSA/HRA Silver 2000 Summary of Benefits

Non-Integrated Deductible

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLNESS PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/sharecare** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[2,3]		
Individual/Family	$2,000 Individual/$4,000 Family (aggregate)	$4,000 Individual/$8,000 Family (aggregate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,4,5]		
Individual/Family	$6,550 Individual/$13,100 Family (separate)	$9,000 Individual/$18,000 Family (separate)
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge*
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[6]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	Deductible, then $50 per visit	Deductible, then $150 per visit
Office Visits for Illness—PCP[6,7]	No charge* after deductible	Deductible, then $65 per visit
Office Visits for Illness—Specialist[6,7]	Deductible, then $45 per visit	Deductible, then $65 per visit
Allergy Testing[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Allergy Shots[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Physical, Speech, and Occupational Therapy[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Chiropractic[6]	Deductible, then $45 per visit	Deductible, then $65 per visit
Acupuncture[6]	Not covered	Not covered
IMMEDIATE AND EMERGENCY SERVICES		
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	No charge* after deductible	Deductible, then $65 per visit
Urgent Care Center[8] (such as Patient First or ExpressCare)	Deductible, then $50 per visit	In-network deductible, then $50 per visit
Hospital Emergency Room Services[8]		
■ Facility	Deductible, then $200 per visit (waived if admitted)	In-network deductible, then $200 per visit (waived if admitted)
■ Physician	Deductible, then $45 per visit	In-network deductible, then $45 per visit
Ambulance (if medically necessary)[8]	Deductible, then $45 per service	In-network deductible, then $45 per service

HealthyBlue PPO HSA/HRA Silver 2000 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
DIAGNOSTIC SERVICES		
Labs		
■ Non-Hospital/Freestanding Facility	No charge* after deductible	Deductible, then $50 per visit
■ Hospital	Deductible, then $75 per visit	Deductible, then $125 per visit
X-ray		
■ Non-Hospital/Freestanding Facility	No charge* after deductible	Deductible, then $50 per visit
■ Hospital	Deductible, then $100 per visit	Deductible, then $150 per visit
Imaging		
■ Non-Hospital/Freestanding Facility	Deductible, then $100 per visit	Deductible, then $150 per visit
■ Hospital	Deductible, then $300 per visit	Deductible, then $400 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgery (Non-Hospital)		
■ Facility	Deductible, then $100 per visit	Deductible, then $200 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Outpatient Surgery (Hospital)		
■ Facility	Deductible, then $200 per visit	Deductible, then $300 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Inpatient Surgery and Hospital Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge* after deductible	Deductible, then $65 per visit
Hospice (Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period)	No charge* after deductible	Deductible, then $65 per visit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then $45 per admission	Deductible, then $65 per admission
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $65 per visit
Delivery and Facility Services	Deductible, then $500 per admission	Deductible, then $600 per admission
Artificial and Intrauterine Insemination[6,9]	Not covered	Not covered
In Vitro Fertilization Procedures[6,9]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	No charge* after deductible	Deductible, then $65 per visit
Outpatient Services		
■ Facility	Deductible, then $50 per visit	Deductible, then $65 per visit
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
Inpatient Services		
■ Facility	Deductible, then $500 per admission	Deductible, then $600 per admission
■ Physician	Deductible, then $45 per visit	Deductible, then $65 per visit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids	Not covered	Not covered

HealthyBlue PPO HSA/HRA Silver 2000 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
PRESCRIPTION DRUGS[10,11]		
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List	
Annual Prescription Drug Deductible	Subject to combined medical and prescription drug deductible	
Preventive Drugs	No charge*	
Oral Chemo Drugs and Diabetic Supplies	HSA - No charge* after deductible; HRA - No charge*	
Generic Drugs	30-day & 90-day (maintenance drugs only) supplies - No charge* after deductible	
Preferred Brand Drugs[12]	30-day supply Deductible, then $45; 90-day supply Deductible, then $90 (maintenance drugs only)	
Non-preferred Brand Drugs[13]	30-day supply Deductible, then $65; 90-day supply Deductible, then $130 (maintenance drugs only)	
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $100 maximum; 90-day supply Deductible, then 50% up to $200 maximum (maintenance drugs only)	
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $150 maximum; 90-day supply Deductible, then 50% up to $300 maximum (maintenance drugs only)	
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)		
Annual Dental Deductible	$25	$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	No charge*	20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3 Aggregate - For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.
4 Separate - 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. The out-of-pocket maximum includes deductibles, copays and coinsurance.
5 All drug costs are subject to the in-network out-of-pocket maximum.
6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
9 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options forinfertility. Preauthorization required.
10 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug
11 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
12 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
13 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

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

The benefits described are issued under form numbers: DC/CF/SHOP/GC (R 1/19) • DC/CF/SHOP/PPO/EOC (1/17) • DC/GHMSI/DOL APPEAL (R. 1/17) • DC/CF/SHOP/PPO/DOCS (1/17) • DC/CF/HB PPO CDH/SIL 2000 (1/19) • DC/CF/HB PPO/GOLD 1500 (1/19) • DC/CF/HB PPO/PLAT 500 (1/19) • DC/CF/BLCRD (R. 6/18) • DC/CF/MEM/BLCRD (R. 6/18) • DC/CF/ANCILLARY AMEND (10/12) • DC/CF/SHOP/ELIG AMEND (1/17) • DC/CF/SHOP/2019 AMEND (1/19) • DC/CF/SG/CCHRADM (1/19) • DC/CF/PT PROTECT (9/10) • DC/GHMSI/HEALTH GUARANTEE 6/18 • DC/CF/SG/INCENT (R. 1/19) • DC/CF/SHOP/ELIG (1/14) and any amendments.

CareFirst

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

Foreign Language Assistance

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

አማርኛ (Amharic) **ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።**

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

ततथयिों का उल्लेख ी और आपके ललए ककसी तनयत समय-सीमा के भीतर काम करना ज़रूरी ी। आपको यजिानकारीऔर सबथं ति सयिता अपनी भाषा में तनःशिल्क पाने का अथकिार ै। सदस्यों को अपने पचिान पत्र के पीछे हदए गए फोननबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते ैं और जब तक 0 दबाने के ललए न कि जाए, तब तक सवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर हदया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fù à-fṹá-fĩ̀in nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwɛ̀ 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-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fũ̀ùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖɛ́ĩn nyɛ. Nyɔ tɔ̀ɔ sɛ́ĩn mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàɖàïn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jʉ̃ĩn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nĩ̀in ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাাংলা (Bengali) লক্ষ্য করুন: এই ননাটশিে আপনার ববমা কভাশরজ সম্পশকে তথ্য রশশেে। এর মশযয গুরুত্বপূর্ে তাবরখ থ্াকশত পাশর এবাং বনবদে ষ্ট তাবরশখর মশযয আপনাশক পদশক্ষ্প বনশত হশত পাশর। ববনা খরশে বনশজর ভাষাে এই তথ্য পাওোর এবাং সহাতো পাওোর অবযকার আপনার আশে। সদসযশদরশক তাশদর পবরপেশরে বপশেন থ্াকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টপিশত না বলা পর্ন্ত অশপক্ষ্া করশত পাশরন। র্খন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলনু এবাং আপনাশক নদাভাষীর সশে সাংরু্ক্ত করা হশব।

اردو *(Urdu)* توجہ : یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے- اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکنہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے- آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہکیے 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 دیگرلوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں- ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبانبتائیں 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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 855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Dine Bizaad *(Navajo)* Ge': Dif bee it hane'igif bii' dahǫ́áQ bee eedahǫ́zin beeso ach' h naanil nik'ist'i'fgii ba. Bii' dahǫ́áQQ doo fiyisif yoolkaaligif dǫ́ǫ́ t'aadoo le'e adadoolyłiligii da yǫ́keedgo t'aa doo bee e'e'aahi ajiil'łih. Bee na ahǫ́ǫ́t'i' dii bee it hane' dǫ́ǫ́ nika'adoowot t'aa nfnizaad bee t'aa jiik'e. Atah danilinigif beesh bee hane'e bee wǫ́tta'igif nitt'izgo bee nee hǫ́dolzinfgif bikeed , bikaa' bich'l' hodoonihjʃ́'. Aadǫ́ǫ́ naanata' ef kojl' dahǫ́doolnih įǫ́ǫ́ǫ̨ǫ́ǫ̨ǫ́ǫ́ǫ́ǫ́ą́ dǫ́ǫ́ yii diitts'llt yattł'łgif t'aa nflefjʃ́ aadǫ́ǫ́ ef bikee'dǫ́ǫ́ naasbc;ác;ás bit adidiilchit. Aka'anidaalwǫ́'fgif neidiit go, saad bee yanitt'i'fgif yii diikit dǫ́ǫ́ ata' halne'e la nfka'adoolwot.

BluePreferred PPO HSA/HRA Silver 2000 Summary of Benefits

Integrated Deductible

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers and facilities	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
WELLNESS PROGRAM & BLUE REWARDS		
Visit **www.carefirst.com/sharecare** for more information.	You have access to a comprehensive wellness program as part of your medical plan. You also have Blue Rewards, an incentive program where you can get rewarded for completing certain activities.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[2,3]		
Individual/Family	$2,000 Individual/$4,000 Family (aggregate)	$4,000 Individual/$8,000 Family (aggregate)
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[2,4,5]		
Individual/Family	$5,500 Individual/$11,000 Family (separate)	$9,000 Individual/$18,000 Family (separate)
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge*
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[6]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable (also applies to Artificial Insemination and In Vitro Fertilization on page 2)	Deductible, then $50 per visit	Deductible, then $150 per visit
Office Visits for Illness—PCP[6,7]	Deductible, then $25 per visit	Deductible, then $70 per visit
Office Visits for Illness—Specialist[6,7]	Deductible, then $50 per visit	Deductible, then $70 per visit
Allergy Testing[6]	Deductible, then $50 per visit	Deductible, then $70 per visit
Allergy Shots[6]	Deductible, then $50 per visit	Deductible, then $70 per visit
Physical, Speech, and Occupational Therapy[6]	Deductible, then $50 per visit	Deductible, then $70 per visit
Chiropractic[6]	Deductible, then $50 per visit	Deductible, then $70 per visit
Acupuncture[6]	Not covered	Not covered
IMMEDIATE AND EMERGENCY SERVICES		
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	Deductible, then $25 per visit	Deductible, then $70 per visit
Urgent Care Center[8] (such as Patient First or ExpressCare)	Deductible, then $100 per visit	In-network deductible, then $100 per visit
Hospital Emergency Room Services[8]		
■ Facility	Deductible, then $250 per visit (waived if admitted)	In-network deductible, then $250 per visit (waived if admitted)
■ Physician	Deductible, then $50 per visit	In-network deductible, then $50 per visit
Ambulance (if medically necessary)[8]	Deductible, then $50 per service	In-network deductible, then $50 per service

BluePreferred PPO HSA/HRA Silver 2000 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
DIAGNOSTIC SERVICES		
Labs		
■ Non-Hospital/Freestanding Facility	Deductible, then $25 per visit	Deductible, then $75 per visit
■ Hospital	Deductible, then $50 per visit	Deductible, then $150 per visit
X-ray		
■ Non-Hospital/Freestanding Facility	Deductible, then $50 per visit	Deductible, then $100 per visit
■ Hospital	Deductible, then $100 per visit	Deductible, then $150 per visit
Imaging		
■ Non-Hospital/Freestanding Facility	Deductible, then $250 per visit	Deductible, then $300 per visit
■ Hospital	Deductible, then $500 per visit	Deductible, then $550 per visit
SURGERY AND HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgery (Non-Hospital)		
■ Facility	Deductible, then $300 per visit	Deductible, then $400 per visit
■ Physician	Deductible, then $50 per visit	Deductible, then $70 per visit
Outpatient Surgery (Hospital)		
■ Facility	Deductible, then $400 per visit	Deductible, then $500 per visit
■ Physician	Deductible, then $50 per visit	Deductible, then $70 per visit
Inpatient Surgery and Hospital Services		
■ Facility	Deductible, then $500 per day (3 day maximum payment per admission)	Deductible, then $600 per day (3 day maximum payment per admission)
■ Physician	Deductible, then $50 per visit	Deductible, then $70 per visit
HOSPITAL ALTERNATIVES		
Home Health Care (limited to 90 visits per episode of care)	No charge* after deductible	Deductible, then $70 per visit
Hospice (Inpatient—limited to 60 days per hospice eligibility period; Outpatient—limited to 180 day hospice eligibility period)	No charge* after deductible	Deductible, then $70 per visit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then $50 per day	Deductible, then $70 per day
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then $70 per visit
Delivery and Facility Services	Deductible, then $500 per day (3 day maximum payment per admission)	Deductible, then $600 per day (3 day maximum payment per admission)
Artificial and Intrauterine Insemination[6,9]	Not covered	Not covered
In Vitro Fertilization Procedures[6,9]	Not covered	Not covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER—(Members are responsible for both physician and facility fees)		
Office Visits	Deductible, then $25 per visit	Deductible, then $70 per visit
Outpatient Services		
■ Facility	Deductible, then $50 per visit	Deductible, then $70 per visit
■ Physician	Deductible, then $50 per visit	Deductible, then $70 per visit
Inpatient Services		
■ Facility	Deductible, then $500 per day (3 day maximum payment per admission)	Deductible, then $600 per day (3 day maximum payment per admission)
■ Physician	Deductible, then $50 per visit	Deductible, then $70 per visit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearing Aids	Not covered	Not covered

BluePreferred PPO HSA/HRA Silver 2000 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1]
PRESCRIPTION DRUGS[10,11]		
Formulary List	Visit **www.carefirst.com/acarx** to locate Formulary List	
Annual Prescription Drug Deductible	Subject to combined medical and prescription drug deductible	
Preventive Drugs	No charge*	
Oral Chemo Drugs and Diabetic Supplies	HSA - No charge* after deductible; HRA - No charge*	
Generic Drugs	30-day supply Deductible, then $10; 90-day supply Deductible, then $20 (maintenance drugs only)	
Preferred Brand Drugs[12]	30-day supply Deductible, then $45; 90-day supply Deductible, then $90 (maintenance drugs only)	
Non-preferred Brand Drugs[13]	30-day supply Deductible, then $65; 90-day supply Deductible, then $130 (maintenance drugs only)	
Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $100 maximum; 90-day supply Deductible, then 50% up to $200 maximum (maintenance drugs only)	
Non-Preferred Specialty Drugs (must be filled through Exclusive Specialty Pharmacy Network)	30-day supply Deductible, then 50% up to $150 maximum; 90-day supply Deductible, then 50% up to $300 maximum (maintenance drugs only)	
PEDIATRIC VISION—(Through the end of the calendar year in which the dependent turns 19)		
Routine Exam (limited to 1 visit/benefit period)	No charge*	Total charge minus $40 reimbursement
Frames and Contact Lenses—Pediatric Collection Only	No charge*	Reimbursements apply
Spectacle Lenses	No charge*	Reimbursements apply
PEDIATRIC DENTAL—(Through the end of the calendar year in which the dependent turns 19)		
Annual Dental Deductible	$25	$50
Class I Preventative & Diagnostic Services—Exams (2 per year). Cleanings (2 per year), fluoride treatments (2 per year), sealants, bitewing X-rays (2 per year), full mouth X-ray (one every 3 years)	No charge*	20% of Allowed Benefit
Class II Basic Services—Fillings (amalgam or composite), simple extractions, non-surgical periodontics	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class III Major Services—Surgical periodontics, endodontics, oral surgery	Deductible, then 20% of Allowed Benefit	Deductible, then 40% of Allowed Benefit
Class IV Major Services—Restorative Crowns, dentures, inlays and onlays	Deductible, then 50% of Allowed Benefit	Deductible, then 65% of Allowed Benefit
Class V Medically Necessary Orthodontic Services	50% of Allowed Benefit	65% of Allowed Benefit

Note: Allowed Benefit is the fee that providers in the network have agreed to accept for a particular service. The 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.

1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 In- and out-of-network deductible and out-of-pocket maximums do not contribute to each other.
3 Aggregate - For family coverage only: The family deductible must be met before any member starts receiving benefits. The deductible may be met by one member or any combination of members.
4 Separate - 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. The out-of-pocket maximum includes deductibles, copays and coinsurance.
5 All drug costs are subject to the in-network out-of-pocket maximum.
6 If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.
7 "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.
8 If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.
9 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options forinfertility. Preauthorization required.
10 Except for emergency services or out-of-area urgent care, if a member goes to a non-participating pharmacy, the member is responsible for the copay/coinsurance for the drug plus the difference between the allowed charge and the actual charge for that drug (called balance billed amount). The balance billed amount does not contribute to the out-of-pocket maximum.
11 Benefits for Specialty Drugs are only available when Specialty Drugs are purchased from and dispensed by a specialty Pharmacy in the Exclusive Specialty Pharmacy Network.
12 If a Generic drug becomes available for a Preferred Brand drug, the Preferred Brand drug moves to the Non-preferred Brand drug tier.
13 If a provider prescribes a Non-preferred Brand drug, and the Member selects the Non-preferred Brand drug when a Generic drug is available, the Member shall pay the applicable Copayment or Coinsurance as stated in the Schedule of Benefits plus the difference between the price of the Non-preferred Brand drug and the Generic drug up to the cost of the drug. This amount will not contribute to the Out-of-Pocket Maximum.

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

The benefits described are issued under form numbers: DC/CF/SHOP/GC (R 1/19) • DC/CF/SHOP/PPO/EOC (1/17) • DC/GHMSI/DOL APPEAL (R. 1/17) • DC/CF/SHOP/PPO/DOCS (1/17) • DC/CF/BP PPO/1000 90-70 (1/19) • DC/CF/BP PPO BF HSA/SIL 1500 (1/19) • DC/CF/BP PPO CDH/2000 80-60 (1/19) • DC/CF/BP PPO CDH/SIL 1500 (1/19) • DC/CF/BP PPO CDH/SIL 2000 (1/19) • DC/CF/BP PPO/GOLD 500 (1/19) • DC/CF/BP PPO/GOLD 1000 (1/19) • DC/CF/BP PPO/GOLD 1500 (1/19) • DC/CF/BP PPO/PLAT 0 (1/19) • DC/CF/BP PPO/PLAT 500 (1/19) • DC/CF/BP PPO/SIL 1000 (1/19) • DC/CF/BLCRD (R. 6/18) • DC/CF/MEM/BLCRD (R. 6/18) • DC/CF/ANCILLARY AMEND (10/12) • DC/CF/SHOP/ELIG AMEND (1/17) • DC/CF/SHOP/2019 AMEND (1/19) • DC/CF/SG/CCHRADM (1/19) • DC/CF/PT PROTECT (9/10) • DC/GHMSI/HEALTH GUARANTEE 6/18 • DC/CF/SG/INCENT (R. 1/19) • DC/CF/SHOP/ELIG (1/14) and any amendments.

CareFirst

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 7/12/18)

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

CareFirst:

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

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

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

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

Civil Rights Coordinator, Corporate Office of Civil Rights

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

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

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

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

Foreign Language Assistance

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

አማርኛ (Amharic) **ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።**

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

ततथयिों का उल्लेख ी और आपके ललए ककसी तनयत समय-सीमा के भीतर काम करना ज़रूरी ी। आपको यजिानकारीऔर सबथं ति सयिता अपनी भाषा में तनःशिल्क पाने का अथकिार ै। सदस्यों को अपने पचिान पत्र के पीछे हदए गए फोननबर पर कॉल करना चाहएि। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते ैं और जब तक 0 दबाने के ललए न कि जाए, तब तक सवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर हदया जाएगा।

Ɓǎsɔ́ɔ̀-wùɖù (Bassa) Tò Đùǔ Cáo! Bɔ̃ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fù à-fṹá-fĩ̀in nyɛɛ jè dyí. Bɔ̃ nìà kɛ ɓéɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwɛ̀ 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-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fũ̀ùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖɛ́ĩn nyɛ. Nyɔ tɔ̀ɔ sɛ́ĩn mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàɖàïn hwɛ̀. Ɔ jǔ ké nyɔ ɖò dyi m̀ gɔ̃ jʉ̃ĩn, po wuɖu m̀ mɔ́ poɛ dyiɛ, ké nyɔ ɖò mu ɓó nĩ̀in ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাাংলা (Bengali) লক্ষ্য করুন: এই ননাটশি আপনার ববমা কভাশরজ সম্পশক তথ্য রশশে। এর মশযয গুরুত্বপূর্ তাবরখ থ্াকশত পাশর এবাং বনবদ ষ্ট তাবরশখর মশযয আপনাশক পদশক্ষ্প বনশত হশত পাশর। ববনা খরশ বনশজর ভাষা এই তথ্য পাওোর এবাং সহাতো পাওোর অবযকার আপনার আশ। সদসযশদরশক তাশদর পবরপেশরে বপশেন থ্াকা নম্বশর কল করশত হশব। অশনযরা 855-258-6518 নম্বশর কল কশর 0 টপিশত না বলা পর্ন্ত অশপক্ষ্া করশত পাশরন। র্খন নকাশনা এশজন্ট উত্তর নদশবন তখন আপনার বনশজর ভাষার নাম বলনু এবাং আপনাশক নদাভাষীর সশ সাংরুক্ত করা হশব।

اردو *(Urdu)* توجہ : یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے- اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکنہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے- آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہکیے 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 دیگرلوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں- ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبانبتائیں 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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 855-258-6518번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Dine Bizaad *(Navajo)* Ge': Dif bee it hane'igif bii' dahǫ́áQ bee eedahǫ́zin beeso ach' h naanil nik'ist'i'fgii ba. Bii' dahǫ́áQQ doo fiyisif yoolkaaligif dǫ́ǫ́ t'aadoo le'e adadoolyłiligii da yǫ́keedgo t'aa doo bee e'e'aahi ajiil'łih. Bee na ahǫ́ǫ́t'i' dii bee it hane' dǫ́ǫ́ nika'adoowot t'aa nfnizaad bee t'aa jiik'e. Atah danilinigif beesh bee hane'e bee wǫ́tta'igif nitt'izgo bee nee hǫ́dolzinfgif bikeed , bikaa' bich'l' hodoonihjʃ́'. Aadǫ́ǫ́ naanata' ef kojl' dahǫ́doolnih įǫ́ǫ́ǫ̨ǫ́ǫ̨ǫ́ǫ́ǫ́ǫ́ǫ́ą́ dǫ́ǫ́ yii diitts'llt yattł'łgif t'aa nflefjʃ́ aadǫ́ǫ́ ef bikee'dǫ́ǫ́ naasbc;ác;ás bit adidiilchit. Aka'anidaalwǫ́'fgif neidiit go, saad bee yanitt'i'fgif yii diikit dǫ́ǫ́ ata' halne'e la nfka'adoolwot.