CareFirst

Family of health care plans

Consumer Health Insurance Plans 2019

For residents of Washington, D.C. who buy their own insurance

Welcome

Thank you for considering CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) for your health care coverage. As the largest health care insurer in the Mid-Atlantic region, we know how much you and your family depend on us for your health coverage. It's a responsibility we take very seriously, as we have with your parents, grandparents, friends and neighbors.

We created this book to help you research and choose the plan that best suits your specific needs. For 2019, CareFirst offers the following plans:

- BlueChoice HMO Young Adult $7,900*
- BlueChoice HMO Standard Bronze $6,650
- BluePreferred PPO Standard Bronze $6,650
- BlueChoice HMO HSA Standard Bronze $6,200
- BluePreferred PPO HSA Standard Bronze $6,200
- BlueChoice HMO Standard Silver $3,500
- BluePreferred PPO Standard Silver $3,500
- BlueChoice HMO HSA Gold $1,500
- BluePreferred PPO HSA Gold $1,500
- BlueChoice HMO Standard Gold $500
- BluePreferred PPO Standard Gold $500
- BlueChoice HMO Standard Platinum $0
- BluePreferred PPO Standard Platinum $0

CareFirst is an affiliate of the Blue Cross Blue Shield Association. When you choose us as your health insurer, you are protected by the nation's oldest and largest family of independent health benefits companies. For over 80 years, we have provided our community with health care coverage and are committed to being there when you need us for many years to come.

If you have any questions as you read through this book, visit us at **carefirst.com/individual** or give us a call at 800-544-8703, Monday–Friday 8 a.m. to 6 p.m. and Saturday, 8 a.m. to noon.

Sincerely,

Rebecca A. Calhoun
Senior Director, Consumer Direct Sales and Regional Offices

*Available to individuals under the age of 30 and those who qualify for a hardship exemption. Visit your state's Exchange for more details.

Contents

The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or CareFirst.

Before You Choose a Plan

To choose the best plan for your needs, you should:

Understand metal levels

Under the Affordable Care Act (ACA) there are four categories of health coverage—Bronze, Silver, Gold and Platinum—called metal levels. All health plans fall into a metal level depending on the share of health care expenses they cover. For example, bronze plans have higher deductibles than other metal level plans.

In Washington, D.C., CareFirst offers plans in the following metal levels:

- Bronze
- Silver
- Gold
- Platinum

CareFirst also offers a Catastrophic plan (BlueChoice Young Adult) for individuals under age 30, or individuals with a hardship exemption.

What is a standard plan?

Standard plans are plan designs that have standardized cost-sharing (i.e. deductible, out-of-pocket maximum, copays and coinsurance) for covered health services. All insurance carriers are required to sell standard plans on the DC Exchange. With standard plans, the main difference is the provider network offered by each insurer.

Consider a Health Savings Account

A Health Savings Account (HSA) is a tax-exempt medical savings account that can be used to pay for your own, and your dependents', eligible health expenses. HSAs enable you to pay for eligible health expenses and save for future qualified health expenses on a tax-free basis. We offer four health insurance plans that coordinate with an HSA. Look for HSA in the plan name.

Look into financial assistance

There are two types of financial assistance (also called subsidies) available:

A tax credit to help pay your monthly premium—This subsidy helps reduce your monthly premium. Once you qualify, your tax credit will be sent to CareFirst and applied to your bill, reducing your premium. If you qualify for this type of assistance, you can use it toward the purchase of any plan—Bronze, Silver, Gold or Platinum (excludes the BlueChoice Young Adult plan).

A subsidy to lower your out-of-pocket expenses—This subsidy helps limit how much you spend on out-of-pocket expenses like copays, coinsurance and deductibles. By lowering these out-of-pocket costs, your health plan begins paying 100 percent of your costs sooner than it would have without the subsidy. If you qualify and want to take advantage of this type of financial assistance, you must purchase a Silver metal level plan.

All Washington, D.C. plans must be purchased through the DC Health Link, but you can use this brochure to examine your choices and determine your best options.

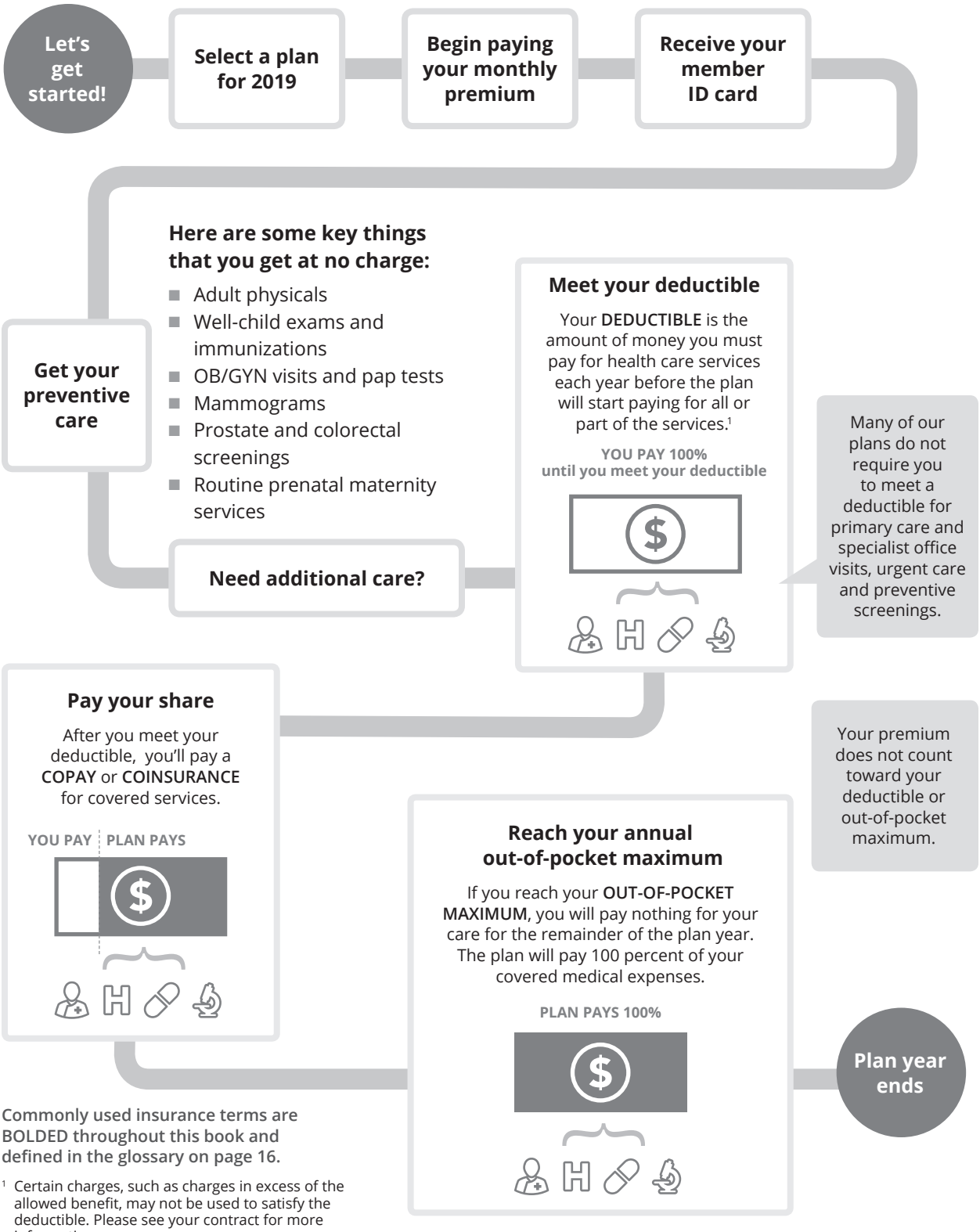
Note: If you are an existing member and you qualified for financial assistance in 2018 and did not elect automatic reassessment, you need to contact the the DC Health Link. You will be re-evaluated for financial assistance for 2019 during Open Enrollment from November 1, 2018–January 31, 2019.

Individuals earning up to $48,560* and a family of four earning up to $100,400* can qualify for financial assistance to help pay for their health insurance premiums.

*income based on 2018 federal poverty levels

How Health Insurance Works

To help you understand your health plan options, it's important to understand a bit about health insurance. The graphic below explains how health insurance works and defines some key terms.



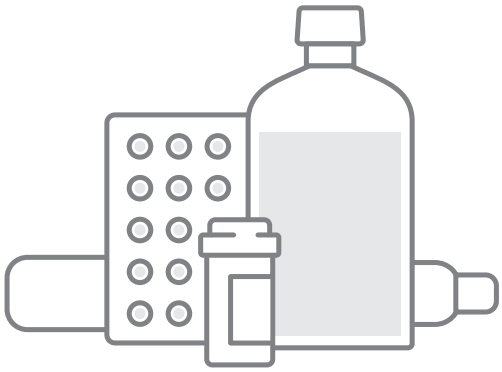
Commonly used insurance terms are BOLDED throughout this book and defined in the glossary on page 16.

[1] Certain charges, such as charges in excess of the allowed benefit, may not be used to satisfy the deductible. Please see your contract for more information.

Included with Every CareFirst Plan

CareFirst health plans are designed with your health in mind. All individual and family plans include:

- **Prescription drug coverage**
- **Vision examination for members over age 19**
- **Dental and vision coverage for members under age 19**



Prescription drug coverage

As a CareFirst member, your prescription coverage includes:

- A nationwide network of more than 69,000 participating pharmacies.
- Access to thousands of covered prescription drugs on our formulary (drug list), divided into tiers. The price you pay for a drug is determined by the tier it falls into.
  - **Generic Drugs (Tier 1)**—Generic drugs are equally safe and effective as brand-name drugs, but generics cost up to 85 percent less.* Ask your doctor if your prescription medication can be filled with a generic alternative.
  - **Preferred Brand-Name Drugs (Tier 2)**—Brand-name drugs that are not yet available in generic form, but have been reviewed for quality, effectiveness, safety and cost effectiveness by an independent national committee of health care professionals.
  - **Non-Preferred Brand-Name Drugs (Tier 3)**—These drugs often have a generic or preferred brand drug option where your cost-share will be lower. You will pay more for drugs in this tier. If you choose a non-preferred drug when a generic is available, you will pay the non-preferred copay along with the difference in price between the generic and non-preferred drug.
  - **Preferred Specialty Drugs (Tier 4)**—Consist of generic and brand-name drugs used to treat chronic, complex and/or rare health conditions.These drugs may have a lower cost-share than non-preferred specialty drugs.
  - **Non-Preferred Specialty Drugs (Tier 5)**—These drugs often have a generic or preferred specialty drug option where your cost-share will be lower.
- Mail Service Pharmacy, our convenient and fast mail order drug program.
  - Save money on your maintenance medications—those drugs taken daily to treat a chronic condition like high cholesterol—by having them delivered right to your home. You can get up to a 90-day supply of your maintenance medications for the cost of two copays.
- Coordinated medical and pharmacy programs to help improve your overall health and reduce costs.
- Personalized care management notices detailing cost savings opportunities, safety alerts and important drug information.

We've included more information on prescription benefits by health plan in the fold-out chart included with this book. Our drug list formulary can be found at **carefirst.com/acarx**.

* https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/GenericDrugs/ucm167991.htm

Health & wellness

Ready to take charge of your health? CareFirst has partnered with Sharecare* to bring you a wellness experience that puts the power of health in your hands.

Your new wellness program provides a wealth of tools and resources, as well as easy-to-understand recommendations and insights that reflect your individual interests and needs—all tailored to help you live your healthiest life. Access these exclusive features whenever, wherever you want:

- **RealAge®**: In just a few minutes, the RealAge online health assessment will help you determine the physical age of your body, compared to your calendar age.
- **Personalized newsfeed:** Receive content based on your health and well-being goals, as well as your motivation and interests.
- **Trackers:** Connect your wearable devices to monitor daily habits like stress, sleep, steps, nutrition and more.
- **Challenges:** Stay motivated to achieve your health goals by joining a challenge.
- **Health profile:** Access your health data, including biometric and lab results, vaccine information and medications, all in one place.

You also have access to additional support to help you take on your wellness goals with confidence, including tobacco cessation and financial well-being programs.

Members can visit **carefirst.com/sharecare** for a personalized experience.

Vision coverage

Every CareFirst health plan includes an annual vision examination for everyone covered by your plan. In-network benefits are offered to you through Davis Vision,† our administrator for the plans. Out-of-network benefits are also available.

Coverage for children (up to age 19) includes:		
■ Silver, Gold and Platinum standard plans—one no-charge in-network routine exam per calendar year	■ No copay for frames and basic lenses for glasses or contact lenses in the Davis Vision collection	■ No claims to file when you use a provider who contracts with Davis Vision
■ Bronze Standard Plans—one $50 in-network routine exam per calendar year	■ No copay for frames and basic lenses for glasses or contact lenses in the Davis Vision collection	■ No claims to file when you use a provider who contracts with Davis Vision
■ For BlueChoice Young Adult plans—one no-charge in-network routine exam per calendar year	■ No copay for frames and basic lenses for glasses or contact lenses in the Davis Vision collection (subject to the medical deductible)	■ No claims to file when you use a provider who contract with Davis Vision
Coverage for adults (age 19 and over) includes:		
■ One no-charge in-network routine exam per calendar year	■ Discounts[1] of approximately 30 percent on eyeglass lenses, frames and contacts, laser vision correction, scratch-resistant lens coating and progressive lenses	■ No claims to file when you use a provider who contracts with Davis Vision

To locate a vision provider near you, call Davis Vision at 800-783-5602 or visit **carefirst.com/doctor**.

† Davis Vision is an independent company.

[1] Provider participation varies from year-to-year. Make sure to call in advance to confirm discounts.

* This wellness program is administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members.

Dental coverage for children up to age 19

Did you know that comprehensive dental care can help detect other health problems before they become more serious? The health of your child's teeth also has a major impact on digestion, growth rate and many other aspects of overall health. That's why all CareFirst medical plans provide kids under age 19 with dental benefits at no extra charge.

Pediatric Dental (under 19)	Bronze, Silver, Gold, Platinum Plans		BlueChoice Young Adult Plan	
	In-Network You Pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Cost	Included in your medical plan premium			
Deductible	Not Subject to Deductible		Subject to medical deductible Individual: $7,900 Family: $15,800 (applies to Classes II, III, IV & V)	
Network	Over 5,000 providers in MD, DC and Northern VA; 123,000 dental providers nationally			
Preventive & Diagnostic Services (Class I)—*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 Pediatric Dental Benefit*	No charge (no deducible)	No charge (no deductible)
Basic Services (Class II)—*Fillings (amalgam or composite), simple extractions, non-surgical periodontics*	20% of Allowed Pediatric Dental Benefit*	40% of Allowed Pediatric Dental Benefit*	No charge (after medical deductible)	No charge (after medical deductible)
Major Services—Surgical (Class III)—*Surgical periodontics, endodontics, oral surgery*	20% of Allowed Pediatric Dental Benefit*	40% of Allowed Pediatric Dental Benefit*	No charge (after medical deductible)	No charge (after medical deductible)
Major Services—Restorative (Class IV)—*Crowns, dentures, inlays and onlays*	50% of Allowed Pediatric Dental Benefit*	65% of Allowed Pediatric Dental Benefit*	No charge (after medical deductible)	No charge (after medical deductible)
Orthodontic Services (Class V)—*when medically necessary*	50% of Allowed Pediatric Dental Benefit*	65% of Allowed Pediatric Dental Benefit*	No charge (after medical deductible)	No charge (after medical deductible)

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

* CareFirst payments are based on the CareFirst Dental Allowed Benefit. Participating dentists accept 100% of the CareFirst Dental Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for any amount over the Dental Allowed Benefit. Providers are not required to accept CareFirst's Dental Allowed Benefit on non-covered services. This means you may have to pay your dentist's entire billed amount for these non-covered services. At your dentist's discretion, they may choose to accept the CareFirst Dental Allowed Benefit, but are not required to do so. Please talk with your dentist about your cost for any dental services.

Dental Plans for Adults

Three optional dental plans

For adults age 19 and older, you may want to consider purchasing one of our three dental plans:

- **BlueDental Preferred**
- **Dental HMO**
- **Select Preferred Dental**

	BlueDental Preferred In-network You Pay *(Out-of-Network coverage available)*	
Individual Cost Per Day	Approximately $1 per day*	
Deductible	**Low Option** $100 Individual/$300 Family (applies to Classes I-IV) per calendar year	**High Option** $50 Individual/$150 Family (applies to Classes II, III, IV) per calendar year
Annual Maximum	Plan pays $1,000 maximum (for members age 19 and older)	
Network	Over 5,000 providers in MD, DC and Northern VA; 123,000 dentists nationally	
Preventive & Diagnostic Services (Class I)	**Low Option** No charge after deductible	**High Option** No charge
Basic Services (Class II)— *Fillings, simple extractions, non-surgical periodontics*	20% of Allowed Benefit** after deductible	
Major Services—Surgical (Class III) *Surgical periodontics, endodontics, oral surgery*	20% of Allowed Benefit** after deductible	
Major Services—Restorative (Class IV) *Inlays, onlays, dentures, crowns*	50% of Allowed Benefit** after deductible	
Orthodontic Services (Class V) *(up to age 19)*	50% of Allowed Benefit** (no deductible) when medically necessary	

Please note: The benefit summary above is condensed and does not provide full benefit details.

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

* Visit **carefirst.com/shopdental** for a rate quote based on your age and residential location.

**CareFirst payments are based on the CareFirst Allowed Benefit. Participating dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for any amount over the Allowed Benefit. Providers are not required to accept CareFirst's Allowed Benefit on non-covered services. This means you may have to pay your dentist's entire billed amount for these non-covered services. At your dentist's discretion, they may choose to accept the CareFirst Allowed Benefit, but are not required to do so. Please talk with your dentist about your cost for any dental services.

	Dental HMO[1]	Select Preferred Dental
	In-network Only You Pay	In-network You Pay *(Out-of-network coverage available)*
Individual Cost Per Day	Less than $.40	Less than $.65
Deductible	None	None
Annual Maximum	No maximum	No maximum
Network	Over 580 providers in MD, DC and Northern VA	Over 5,000 providers in MD, DC and Northern VA
Preventive & Diagnostic Services (Class I)	$20 copay per office visit	No charge
Basic Services (Class II)— *Fillings, simple extractions, non-surgical periodontics*	$20-$70 copay per office visit	Not covered
Major Services—Surgical (Class III) *Surgical periodontics, endodontics, oral surgery*	Copays per service	Not covered
Major Services—Restorative (Class IV) *Inlays, onlays, dentures, crowns*	Copays per service	Not covered
Orthodontic Services (Class V) *(up to age 19)*	Child: $2,500 per member Adult: $2,700 per member	Not covered

Please note: The benefit summary above is condensed and does not provide full benefit details.

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

[1] The Dental HMO plan is underwritten by CareFirst BlueChoice, Inc., which is an independent licensee of the Blue Cross and Blue Shield Association.

CareFirst payments are based on the CareFirst Allowed Benefit. Participating dentists accept 100% of the CareFirst Allowed Benefit as payment in full for covered services. Non-participating dentists may bill the member for any amount over the Allowed Benefit. Providers are not required to accept CareFirst's Allowed Benefit on non-covered services. This means you may have to pay your dentist's entire billed amount for these non-covered services. At your dentist's discretion, they may choose to accept the CareFirst Allowed Benefit, but are not required to do so. Please talk with your dentist about your cost for any dental services.

For more information, including an application, just mail in the postage-paid card attached here.

If you'd like to talk to a dental product consultant, please call 855-503-4862.

Mail this card for more information

YES, please rush me more information about the plan(s) that I've checked below. I understand this information is free and I am under no obligation.

Dental Plan Options
☐ BlueDental Preferred
☐ Dental HMO
☐ Select Preferred Dental

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

CareFirst
Family of health care plans

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On the go? Download our mobile app by searching CareFirst in your app store.
Using any mobile device, you can:

- Search for providers and urgent care centers
- Download ID cards to your device
- Save provider information directly to your contacts list
- Receive a notification when your new Explanation of Benefits (EOB) information is ready to view
- View claims and deductible information

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Know Before You Go

Knowing where to go when you need medical care is key to getting treatment with the lowest out-of-pocket costs.

Primary care provider (PCP)

Establishing a relationship with a primary care provider is the best way to receive consistent, quality care. Except for emergencies, your PCP should be your first call when you require medical attention. Your PCP may be able to provide advice over the phone or fit you in for a visit right away.

FirstHelp—free 24-hour nurse advice line

With our free nurse advice line, members can call anytime to speak with a registered nurse. Nurses will discuss your symptoms with you and recommend the most appropriate care.

CareFirst Video Visit

See a doctor 24/7/365 without an appointment! You can consult with a board-certified doctor on your smartphone, tablet or computer. Doctors can treat a number of common health issues, such as flu and pink eye. Visit **carefirstvideovisit.com** for more information.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store and offer accessible care with extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.

Urgent care centers

Urgent care centers have a doctor on staff and are another option when you need care on weekends or after hours.

Emergency room (ER)

An emergency room provides treatment for acute illnesses and trauma. You should call 911 or go straight to the ER if you have a life-threatening injury, illness or emergency. Prior authorization is not needed for emergency room services.

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. This chart shows how costs* (copays) vary for a sample health plan depending on where you choose to get care. Visit carefirst.com/needcare for more information.

When your PCP isn't available	Sample cost	Sample symptoms	24/7	Prescriptions
 **Video visit**	$20	▪ Cough, cold and flu ▪ Pink eye ▪ Ear pain	✔	✔
 **Convenience care**	$20	▪ Cough, cold and flu ▪ Pink eye ▪ Ear infection	✘	✔
 **Urgent care**	$60	▪ Sprains ▪ Cut requiring stitches ▪ Minor burns	✘	✔
 **Emergency room**	$200	▪ Chest pain ▪ Difficulty breathing ▪ Abdominal pain	✔	✔

* The costs in this chart are for illustrative purposes only and may not represent your specific benefits or costs.

Choosing Your Plan

Calculating your total monthly premium

Before you decide on the plan that best fits your needs, you'll likely want to take a look at the cost.

Buying an individual plan

Using the chart, find the plan(s) you are considering and circle the dollar amount that corresponds with how old you will be when your coverage begins (i.e. your age on January 1, 2019). That's your rate.

Buying a family plan

If you are interested in a family plan, each family member is rated individually and your rates are combined to calculate your family premium. To calculate your family premium:

- Circle the rate for you.
- Circle the rate for your spouse (if applicable).
- Circle the rates for your oldest three children under age 21.

If you have more than three children under age 21, all will be covered on your plan but only the three oldest count toward your overall premium.

- Circle the rate for each child age 21-25. Note: children over age 25 must purchase their own health insurance.
- Add all individual rates together to determine your family premium.

2019 Washington, D.C. Rates						
Age	Bronze Level Plans				Silver Level Plans	
	BlueChoice HMO HSA Standard Bronze $6,200	BluePreferred PPO HSA Standard Bronze $6,200	BlueChoice HMO Standard Bronze $6,650	BluePreferred PPO Standard Bronze $6,650	BlueChoice HMO Standard Silver $3,500	BluePreferred PPO Standard Silver $3,500
0-20	$211.84	$239.43	$224.60	$243.59	$254.83	$272.74
21	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
22	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
23	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
24	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
25	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
26	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
27	$235.49	$266.15	$249.67	$270.78	$283.28	$303.18
28	$241.00	$272.38	$255.51	$277.11	$289.90	$310.27
29	$246.18	$278.24	$261.01	$283.07	$296.13	$316.94
30	$252.33	$285.19	$267.53	$290.15	$303.54	$324.87
31	$258.81	$292.51	$274.40	$297.60	$311.33	$333.21
32	$264.64	$299.10	$280.58	$304.30	$318.34	$340.71
33	$270.80	$306.06	$287.11	$311.38	$325.75	$348.64
34	$277.28	$313.38	$293.98	$318.83	$333.54	$356.98
35	$283.75	$320.70	$300.84	$326.27	$341.33	$365.32
36	$290.23	$328.03	$307.71	$333.72	$349.13	$373.66
37	$296.71	$335.35	$314.58	$341.17	$356.92	$382.00
38	$300.27	$339.37	$318.36	$345.27	$361.21	$386.59
39	$303.84	$343.40	$322.14	$349.37	$365.49	$391.17
40	$315.82	$356.95	$334.84	$363.15	$379.91	$406.60
41	$328.13	$370.86	$347.89	$377.30	$394.72	$422.45
42	$341.09	$385.50	$361.63	$392.20	$410.30	$439.13
43	$354.37	$400.51	$375.71	$407.47	$426.28	$456.23
44	$368.30	$416.26	$390.48	$423.49	$443.03	$474.16
45	$382.55	$432.36	$405.59	$439.88	$460.18	$492.51
46	$397.45	$449.20	$421.39	$457.01	$478.10	$511.70
47	$413.00	$466.78	$437.87	$474.89	$496.80	$531.71
48	$429.19	$485.08	$455.04	$493.51	$516.29	$552.56
49	$446.04	$504.12	$472.90	$512.88	$536.55	$574.25
50	$463.53	$523.89	$491.45	$532.99	$557.59	$596.77
51	$481.67	$544.39	$510.68	$553.85	$579.41	$620.12
52	$500.46	$565.62	$530.60	$575.45	$602.01	$644.31
53	$519.89	$587.59	$551.21	$597.80	$625.39	$669.33
54	$540.30	$610.65	$572.84	$621.26	$649.94	$695.61
55	$561.35	$634.45	$595.16	$645.47	$675.26	$722.71
56	$583.38	$659.35	$618.52	$670.80	$701.76	$751.07
57	$606.05	$684.97	$642.56	$696.87	$729.04	$780.26
58	$629.70	$711.70	$667.63	$724.06	$757.48	$810.71
59	$654.32	$739.52	$693.73	$752.37	$787.09	$842.40
60	$679.91	$768.44	$720.86	$781.79	$817.88	$875.35
61	$706.47	$798.46	$749.02	$812.34	$849.83	$909.54
62	$706.47	$798.46	$749.02	$812.34	$849.83	$909.54
63	$706.47	$798.46	$749.02	$812.34	$849.83	$909.54
64	$706.47	$798.46	$749.02	$812.34	$849.83	$909.54
65+*	$706.47	$798.46	$749.02	$812.34	$849.83	$909.54

* If you are age 65 or older, you can only apply if you are not eligible for Medicare.

If you are under age 65 and disabled, you can only apply if you are not eligible for Medicare.

Rates are valid January 1–December 31, 2019 only.

2019 Washington, D.C. Rates							
Age	Gold Level Plans				Platinum Level Plans		Young Adult
	BlueChoice HMO HSA Gold $1,500	BluePreferred PPO HSA Gold $1,500	BlueChoice HMO Standard Gold $500	BluePreferred PPO Standard Gold $500	BlueChoice HMO Standard Platinum $0	BluePreferred PPO Standard Platinum $0	BlueChoice HMO Young Adult $7,900*
0-20	$304.30	$322.68	$339.75	$345.17	$389.08	$397.66	$105.31
21	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
22	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
23	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
24	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
25	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
26	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
27	$338.27	$358.69	$377.67	$383.70	$432.51	$442.05	$117.07
28	$346.18	$367.08	$386.50	$392.67	$442.63	$452.38	$119.81
29	$353.62	$374.98	$394.81	$401.11	$452.15	$462.11	$122.38
30	$362.46	$384.35	$404.68	$411.14	$463.45	$473.66	$125.44
31	$371.77	$394.22	$415.07	$421.70	$475.35	$485.82	$128.66
32	$380.14	$403.10	$424.42	$431.20	$486.06	$496.77	$131.56
33	$388.98	$412.47	$434.29	$441.22	$497.36	$508.32	$134.62
34	$398.29	$422.34	$444.68	$451.78	$509.26	$520.48	$137.84
35	$407.59	$432.21	$455.07	$462.34	$521.16	$532.64	$141.06
36	$416.90	$442.08	$465.46	$472.89	$533.06	$544.80	$144.28
37	$426.21	$451.95	$475.85	$483.45	$544.96	$556.96	$147.50
38	$431.32	$457.37	$481.57	$489.25	$551.50	$563.65	$149.27
39	$436.44	$462.80	$487.28	$495.06	$558.04	$570.34	$151.05
40	$453.66	$481.06	$506.50	$514.59	$580.06	$592.84	$157.00
41	$471.34	$499.80	$526.24	$534.64	$602.66	$615.94	$163.12
42	$489.95	$519.54	$547.02	$555.75	$626.46	$640.27	$169.56
43	$509.03	$539.77	$568.32	$577.39	$650.85	$665.20	$176.17
44	$529.03	$560.98	$590.66	$600.09	$676.44	$691.34	$183.09
45	$549.51	$582.69	$613.52	$623.31	$702.61	$718.10	$190.18
46	$570.91	$605.39	$637.41	$647.59	$729.98	$746.07	$197.58
47	$593.24	$629.07	$662.35	$672.92	$758.54	$775.25	$205.31
48	$616.51	$653.74	$688.32	$699.31	$788.28	$805.65	$213.36
49	$640.70	$679.40	$715.34	$726.75	$819.22	$837.27	$221.74
50	$665.83	$706.04	$743.39	$755.25	$851.34	$870.11	$230.43
51	$691.89	$733.67	$772.48	$784.81	$884.66	$904.16	$239.45
52	$718.87	$762.29	$802.61	$815.42	$919.17	$939.42	$248.79
53	$746.79	$791.89	$833.78	$847.09	$954.86	$975.90	$258.45
54	$776.10	$822.97	$866.51	$880.34	$992.34	$1,014.21	$268.60
55	$806.35	$855.04	$900.28	$914.64	$1,031.01	$1,053.73	$279.06
56	$837.99	$888.60	$935.60	$950.53	$1,071.47	$1,095.08	$290.02
57	$870.56	$923.13	$971.97	$987.48	$1,113.11	$1,137.64	$301.29
58	$904.52	$959.15	$1,009.89	$1,026.00	$1,156.54	$1,182.03	$313.04
59	$939.89	$996.65	$1,049.37	$1,066.12	$1,201.76	$1,228.24	$325.28
60	$976.64	$1,035.63	$1,090.41	$1,107.81	$1,248.76	$1,276.28	$338.00
61	$1,014.80	$1,076.08	$1,133.01	$1,151.09	$1,297.54	$1,326.14	$351.21
62	$1,014.80	$1,076.08	$1,133.01	$1,151.09	$1,297.54	$1,326.14	$351.21
63	$1,014.80	$1,076.08	$1,133.01	$1,151.09	$1,297.54	$1,326.14	$351.21
64	$1,014.80	$1,076.08	$1,133.01	$1,151.09	$1,297.54	$1,326.14	$351.21
65+**	$1,014.80	$1,076.08	$1,133.01	$1,151.09	$1,297.54	$1,326.14	$351.21

* Only available for enrollment to people under the age of 30 or those who qualify for a hardship exemption. Visit DC Health Link for more details.

** If you are age 65 or older, you can only apply if you are not eligible for Medicare.

If you are under age 65 and disabled, you can only apply if you are not eligible for Medicare.

Rates are valid January 1–December 31, 2019 only.

How to Enroll

Once you decide on the CareFirst plan that works best for your needs, all that's left to do is enroll.

Washington, D.C. residents must purchase their qualified health insurance plan through DC Health Link every year.

Visit **dchealthlink.com**

Call the DC Health Link, **855-532-5465**

When your coverage will start

When you enroll in your CareFirst plan through the DC Health Link, please verify your coverage start date with them.

Paying for your plan

After CareFirst has received your enrollment information from DC Health Link, you will be mailed a bill. Please wait for your bill before making a payment.

Learn more about payment options by visiting **carefirst.com/paymentoptions.**

Convenient e-billing

If you set up automated monthly premium payments, your first payment and each remaining payment, will be withdrawn from your bank account and sent to CareFirst automatically. Once you become a member, you can set up recurring payments—using a smartphone, tablet or desktop computer—at **carefirst.com/myaccount** or with the CareFirst mobile app.

Glossary

Here's a quick reference guide to many of the terms used in this book. For more glossary terms, visit our YouTube channel videos at **youtube.com/carefirst**.

Allowed benefit—The maximum dollar amount an insurer will pay for a covered health service, regardless of the provider's actual charge. A provider who participates in the CareFirst BlueCross BlueShield or BlueChoice network cannot charge members more than the allowed benefit amount for any covered service.

Coinsurance—the percentage you pay after you've met your deductible. For example, if your health care plan has a 30 percent coinsurance and the allowed benefit is $100 (the amount a provider can charge a CareFirst member for that service), then your cost would be $30. CareFirst would pay the remaining $70.

Convenience care centers/retail health clinics—tend to be located inside a pharmacy or retail store and offer fast access to treatment for non-emergency care. These centers/clinics offer extended weekend hours and can often see you quickly.

Copay—a fixed dollar amount you pay when you visit a doctor or other provider. For example, you might pay $40 each time you visit a specialist or $300 when you visit the emergency room.

Deductible—the amount of money you must pay each year before CareFirst begins to pay its portion of your claims. For example, if your deductible is $1,000, you'll pay the first $1,000 for health care services covered by your plan and subject to the deductible. CareFirst will start paying for part or all of the services after that. Your deductible will start over each year on January 1. Please note—many of our plans include a variety of services that do not require you to meet the deductible before CareFirst begins paying.

Effective date—If you purchase a plan during the annual open enrollment period, your new plan starts on January 1.

Generic drugs—prescription drugs that work the same as brand-name drugs but cost much less. To learn more about generics and how you can save money, visit **carefirst.com/acarx**.

Health Maintenance Organization (HMO)—BlueChoice HMO plans offer the flexibility to see any of the nearly 44,000 participating providers in the BlueChoice network. Outside of our network, only emergency medical services are covered.

Health Savings Account (HSA)—a special, tax-advantaged account that you set up to save money for current and future health care expenses. The deposits you make to your HSA reduce your taxable income, helping you keep more of your hard-earned money. You can use the money you deposit into your HSA to pay the deductible and other out-of-pocket expenses for you, your spouse and your dependents (even if they're not enrolled in your health care plan) or you can save it for future health care expenses. If you have coverage for your spouse or family, the maximum amount that you can contribute to your HSA is even higher and can reduce your taxable income by whatever amount you contribute.

Non-preferred brand drugs—drugs that are often available in less expensive forms, either as generic or preferred brand drugs. You will pay more for this category of drugs.

Non-preferred specialty drugs—specialty drugs that are likely to have a more cost-effective generic or preferred brand alternative available. This tier has the highest copayment for specialty drugs.

Out-of-pocket maximum—the most you will have to pay for medical expenses and prescriptions in a calendar year. Your out-of-pocket maximum will start over every January 1. Please note: your monthly premium payments do not count toward your out-of-pocket maximum.

Preferred brand drugs—drugs not yet available in generic form chosen for their effectiveness and affordability compared to alternatives. They cost more than generics but less than non-preferred brand drugs.

Preferred specialty drugs—consists of generic and brand-name specialty drugs used to treat chronic, complex and/or rare health conditions. These drugs are generally more cost-effective than other specialty drugs.

Preferred Provider Organization (PPO)—BluePreferred PPO plans offer the most flexibility. Care can be accessed from the PPO network of approximately 47,000 providers locally and thousands nationally. Costs will be higher if you see a doctor who does not participate with a Blue Cross Blue Shield plan.

Premium—the amount you pay each month for your plan, based on the number and age of covered family members and the plan you choose.

Primary care provider (PCP)— the doctor you select as your health care partner. They know and understand you and your health care needs.

Specialty drugs—the highest priced drugs that may require special handling, administration or monitoring. These drugs may be oral or injectable and are used to treat serious or chronic conditions.

Standard plan—Standard plans are plan designs that have standardized cost-sharing (i.e. deductible, out-of-pocket maximum, copays and coinsurance) for covered health services. All insurance carriers are required to sell standard plans on the DC Exchange. With standard plans, the main difference is the provider network offered by each insurer.

Our Commitment to You

CareFirst's privacy practices

The following statement applies to Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield, and to CareFirst BlueChoice, Inc., and their affiliates (collectively, CareFirst).

When you apply for any type of insurance, you disclose information about yourself and/or members of your family. The collection, use and disclosure of this information is regulated by law. Safeguarding your personal information is something that we take very seriously at CareFirst. CareFirst is providing this notice to inform you of what we do with the information you provide to us.

Categories of personal information we may collect

We may collect personal, financial and medical information about you from various sources, including:

- Information you provide on applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information pertaining to your relationship with CareFirst, its affiliates or others, such as your policy coverage, premiums and claims payment history.
- Information (as described in preceding paragraphs) that we obtain from any of our affiliates.
- Information we receive about you from other sources, such as your employer, your provider and other third parties.

How your information is used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your personal, financial and medical information to anyone outside of CareFirst unless we have proper authorization from you or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information.

In addition, we limit access to your personal, financial and medical information to those CareFirst employees, brokers, benefit plan administrators, consultants, business partners, providers and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of your information

In order to protect your privacy, affiliated and nonaffiliated third parties of CareFirst are subject to strict confidentiality laws. Affiliated entities are companies that are a part of the CareFirst corporate family and include health maintenance organizations, third party administrators, health insurers, long-term care insurers and insurance agencies. In certain situations related to our insurance transactions involving you, we disclose your personal, financial and medical information to a nonaffiliated third party that assists us in providing services to you. When we disclose information to these critical business partners, we require these business partners to agree to safeguard your personal, financial and medical information and to use the information only for the intended purpose and to abide by the applicable law. The information CareFirst provides to these business partners can only be used to provide services we have asked them to perform for us or for you and/or your benefit plan.

Changes in our privacy policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your personal, financial and medical information secure it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records. You can always review our current privacy policy online at **carefirst.com**.

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** and click on *Privacy Statement* at the bottom of the page, click on *Health Information* then click on *Notice of Privacy Practices.*

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.
- 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 member ID 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.

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

WASHINGTON, D.C.

Medical Necessity Issues:
Department of Health
Office of the General Counsel
Grievance and Appeals Coordinator
825 North Capitol Street, NE, Room 4119
Washington, D.C. 20002
Phone: 202-442-5977 / Fax: 202-442-4797

Issues other than Medical Necessity:
Department of Insurance, Securities and Banking
1050 First Street, NE, Suite 801
Washington, D.C. 20002
Phone: 202-727-8000

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:

Consumer Protection Division
Office of the Attorney General
441 Fourth Street, NW
Washington, D.C. 20001
Phone: 202-347-3400 TTY: 202-727-3400
Fax: 202-347-8922
website: oag.dc.gov

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.

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 file appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan, it's 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.

Experimental/investigational services

Experimental/investigational means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental/investigational services do not include controlled clinical trials.

Compensation and premium disclosure statement

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

The following information applies to CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield, and to CareFirst BlueChoice, Inc., and their affiliates (collectively, CareFirst).

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your member ID card, or write to:

For plans underwritten by CareFirst BlueChoice, Inc. and Group Hospitalization and Medical Services, Inc.

CareFirst BlueCross BlueShield
CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, D.C. 20065
Attention: Member Services

A. Methods of paying physicians

The following definitions explain how insurance carriers may pay physicians (or other providers) for your health care services.

The examples show how Dr. Jones, an obstetrician/gynecologist, would be compensated under each method of payment.

Salary: A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.

Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.

Capitation: A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.

Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.

Fee-for-service: A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.

Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Discounted fee-for-service: Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.

Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.

Bonus: A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.

An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.

Case rate: The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.

This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related

charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.

B. Percentage of provider payment methods

CareFirst BlueChoice, Inc. is a network model HMO and contracts directly with the primary care and specialty care providers. According to this type of arrangement, CareFirst BlueChoice, Inc. reimburses providers primarily on a discounted fee-for-service payment method. The provider payment method percentages for CareFirst BlueChoice, Inc. are approximately 99 percent discounted fee-for-service with less than 1 percent capitated.

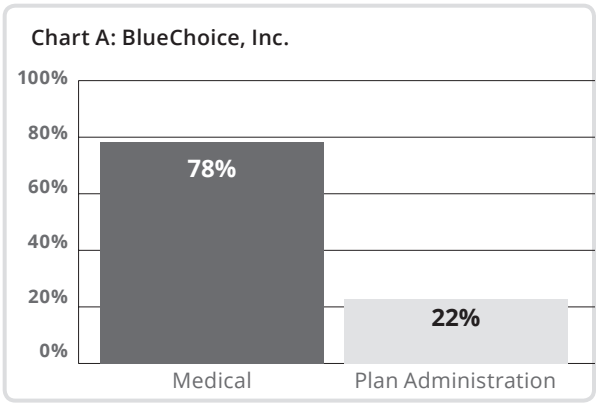
For its Indemnity and Preferred Provider Organization (PPO) plans, CareFirst of Maryland, Inc. and CareFirst BlueCross BlueShield contract directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

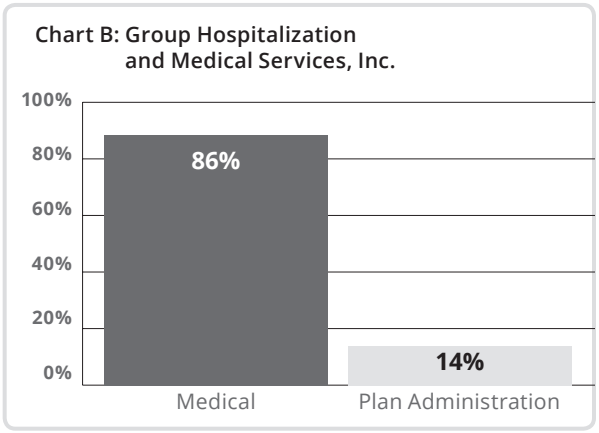
C. Distribution of premium dollars

The bar graph at right illustrates the proportion of every $100 in premium used by CareFirst to pay physicians (or other providers) for medical care expenses and the proportion used to pay for plan administration.

Chart A represents an average for all CareFirst BlueChoice, Inc. HMO accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

Chart B represents an average for all Group Hospitalization and Medical Services, Inc. indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.





Defending Access to Women's Health Care Services Revision Act of 2018

The services set forth below mirrors preventive services under the Patient Protection and Affordable Care Act. These preventive services and contraceptive services are covered when clinically appropriate, under recommendations of the United States Preventive Services Task Force and supporting evidence. Services apply to D.C. plans that have elected or are required to provide these preventive services. Limitations may apply with respect to the availability, setting, frequency, or method of a service or treatment.

These preventive services are offered at no cost to you. This means you don't have to pay a copay or coinsurance, even if you haven't met your deductible. Subscribers are still responsible for their portion of the premiums.

Children

Well child visits (to age 21) to include:

- Autism screening
- Certain diagnostic screenings for newborns
- Cervical dysplasia for sexually active females
- Depression screening
- Developmental screenings—under age 3
- Hearing screening for newborns
- Hematocrit or hemoglobin screening
- HIV screening
- Lead testing
- Obesity screening
- Vision screening
- Health, diet and weight counseling
- Alcohol and drug assessments for older children

Immunizations for children include:

- Diphtheria, Tetanus, Pertussis
- Hepatitis A and Hepatitis B
- Human Papillomavirus (HPV)
- Inactivated Polio
- Influenza
- Influenza B
- Measles, mumps and rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Adults

Preventive care visits include:

- Abdominal aortic aneurysm (one-time) screening
- Alcohol misuse screening
- Anemia screening
- Breast cancer (mammogram)
- BRCA testing for breast/ovarian cancer risk and genetic counseling
- Breastfeeding support, supplies and counseling
- Cervical cancer screening
- Cholesterol screening
- Colon cancer (colonoscopy)
- Depression screening
- Fall Prevention Physical therapy and Vitamin D (OTC*) supplementation to prevent falls in community-dwelling adults (those who are not in assisted living facilities or nursing homes), age 65 years or older who are at increased risk for falls.
- FDA-approved contraceptives and counseling
- Gestational diabetes screening
- Health, diet and weight counseling for qualifying adults
- Hepatitis B and Hepatitis C screening
- High blood pressure screening
- HIV screening
- HPV DNA testing
- Intimate partner, interpersonal and domestic violence screening and counseling

- Lung cancer screening
- Obesity screening
- Osteoporosis screening
- Rh incompatibility and urinary tract infection screenings for pregnant women
- Sexually transmitted diseases
- Tuberculosis screening
- Type 2 diabetes screening
- Tobacco use screening and cessation counseling

FDA-approved contraceptives:

- Cervical cap (P) with spermicide (OTC*)
- Contraceptive implant system (inserted by doctor)
- Contraceptive patch (P)
- Contraceptive ring (P)
- Diaphragm (P) with spermicide (OTC*)
- Female condom (OTC*)
- IUD (inserted by doctor)
- Morning after pill (generic only) (OTC*)
- Oral contraceptive (brand name (P) only when generic equivalent drug is medically inappropriate, as determined by the individual's health care provider). Preauthorization and medical review of brand name oral contraceptives is required.
- Oral contraceptive (generics) (P)
- Shot/injection[1] (generic only) (P)
- Spermicide (OTC*)
- Sponge (OTC*) with spermicide (OTC*)
- Sterilization implant
- Sterilization surgery

Immunizations for adults:

- Hepatitis A and B
- Herpes Zoster
- HPV
- Influenza
- Measles, mumps and rubella
- Diphtheria, Tetanus, Pertussis
- Meningococcal
- Pneumococcal
- Varicella

Breastfeeding supplies (provided under the Durable Medical Equipment (DME) benefits of the contract)

Coverage is provided for:

- Electric breast pump (rental and/or purchase)
- Hospital grade electric breast pump (rental)
- Manual breast pumps (rental and/or purchase)

Replacement supplies include:

- Adapter for breast pump
- Breast pump replacement tubing
- Breast shield and splash protector for use with breast pump
- Cap for breast pump bottle
- Locking ring for breast pump
- Polycarbonate bottle for use with breast pump

Prenatal care:

- Routine prenatal obstetrical office visits
- Lactation counseling

Breast cancer drugs:

- Tamoxifen and Raloxifene for women 35 and older at an increased risk for invasive breast cancer. Preauthorization required

Preventive drugs for adults:

- Aspirin (81mg) (OTC*)
- Colon Preparations–age 50–74 (P)
- Folic Acid—women of childbearing age (P)
- Smoking Cessation (OTC*)
- Vitamin D (600IU–800IU)—age 65 years and older (P)
- Statins (generic low to moderate intensity) — adults age 40 to 75 (P)

Preventive drugs for children:

- Fluoride—preschool age (P)
- Iron—6–12 mo. risk of anemia (OTC*)

Information on preventive services are available at healthcare.gov/coverage/preventive-care-benefits

To verify your benefits, check your benefits contract, your enrollment materials or log into My Account at carefirst.com/myaccount.

*Requires a prescription from a physician, or a D.C., Board certified, network pharmacists for contraceptives. Prescriptions must be filled at a network pharmacy to obtain the zero-cost share. You may be able to receive up to a 12-month supply of contraceptives at one time. Ask your physician or pharmacist if you have any questions regarding dispensing amount.

[1] Includes brand name Depo-SubQ Provera 104 (injection)

(P) Prescription Required

(OTC) Over the Counter

2019 Washington, D.C. Policy Form Numbers

BlueChoice HMO Young Adult $7,900

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO/ YA 7900 SOB (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BlueChoice HMO HSA Standard Bronze $6,200

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO HSA STD/BRZ 6200 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO HSA Standard Bronze $6,200

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP HSA STD/BRZ 6200 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19); DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Bronze $6,650

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/BRZ 6650 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Bronze $6,650

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/BRZ 6650 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19); DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Silver $3,500

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/SIL 3500 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Silver $3,500

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/SIL 3500 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18; DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19); DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

BlueChoice HMO HSA Gold $1,500

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO HSA/GOLD 1500 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO HSA Gold $1,500

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP HSA/GOLD 1500 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19; DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Gold $500

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/GOLD 500 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Gold $500

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/GOLD 500 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19); DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

BlueChoice HMO Standard Platinum $0

DC CFBC EXC HMO IEA (R 1/17); DC CFBC EXC HMO DOCS (1/17); DC/CFBC/EXC/HMO STD/PLAT 0 (1/19); DC/CFBC/DOL APPEAL (R. 1/17); DC/CFBC/MEM/BLCRD (R. 6/18); DC/CFBC/EXC/2019 AMEND (1/19); DC/CFBC/PT PROTECT (9/10)

BluePreferred PPO Standard Platinum $0

DC/CF/EXC/BP/IEA (R. 1/17); DC/CF/BP/EXC/DOCS (1/17); DC/CF/EXC/BP STD/PLAT 0 (1/19); DC/GHMSI/DOL APPEAL (R. 1/17); DC/CF/MEM/BLCRD (R. 6/18); DC/CF/ANCILLARY AMEND (10/12); DC/CF/EXC/2019 AMEND (1/19); DC/GHMSI/HEALTH GUARANTEE 6/18; DC/CF/PT PROTECT (9/10)

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

CDS1260-1P (10/18)

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 ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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